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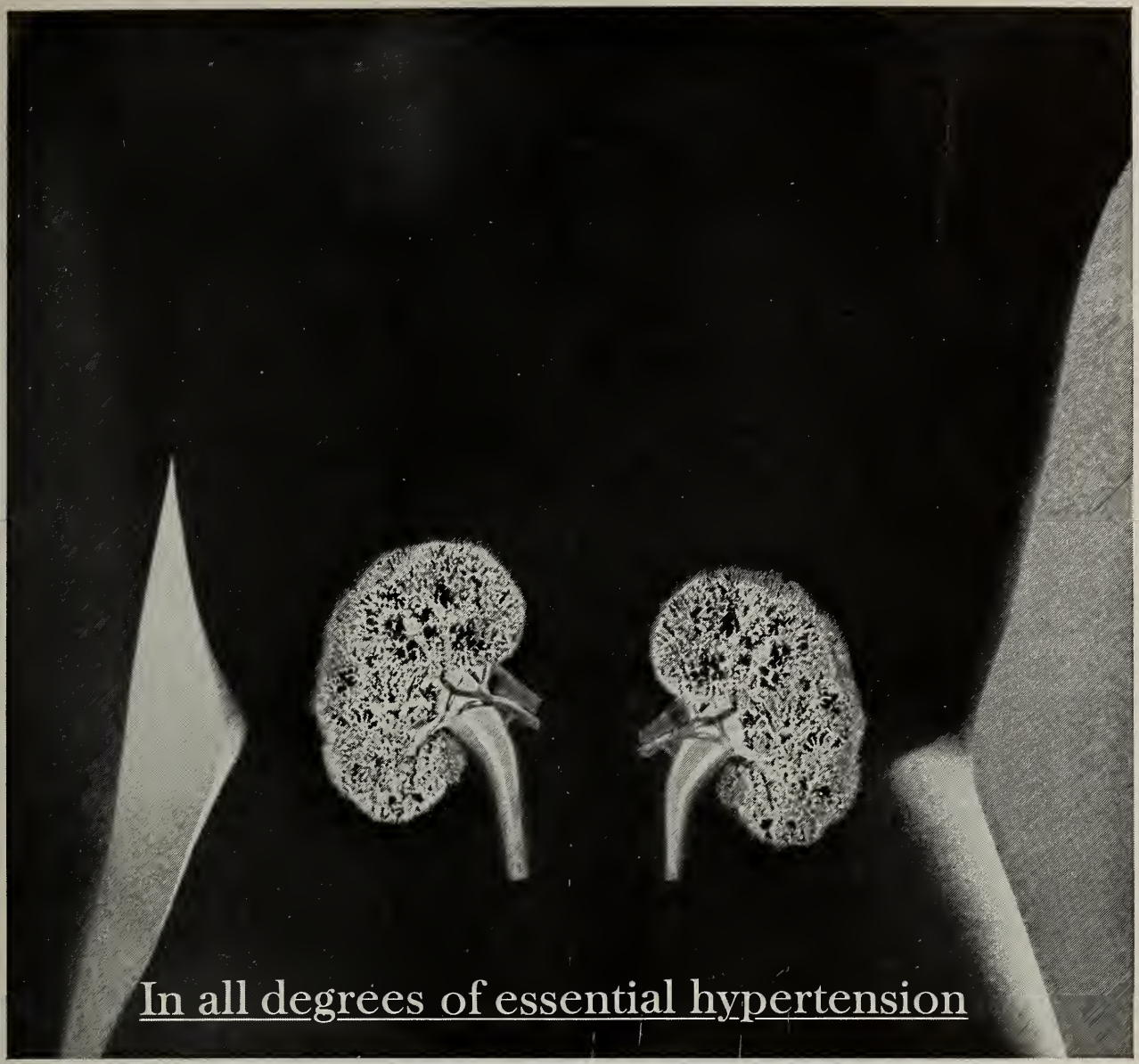
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Vigo	Stuart R. Combs, Terre Haute	Hubert T. Goodman, 410 Rose Dispensary Bldg., Terre Haute
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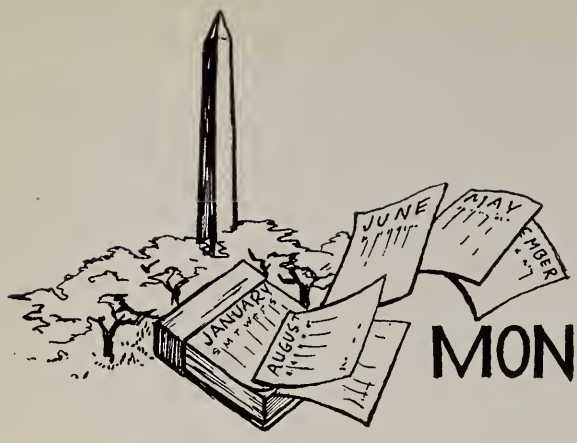
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MONTH IN WASHINGTON

WASHINGTON, D. C. — Both sides squared off for a new legislative battle this session of Congress on the issue of financing a medical-hospital plan for the aged through higher Social Security taxes.

There was no vote on the disputed King-Anderson bill (H.R. 3920) in Congress last year. The House Ways and Means Committee held five of a scheduled nine days of hearings on the bill in November, but broke the hearings off on news of the assassination of President Kennedy. The sessions were scheduled to be concluded in January.

The financial soundness of the Administration's bill was challenged by Ways and Means Committee Chairman Wilbur Mills (D.,Ark.). He told Administration witnesses that if Congress had approved similar legislation in the past, it apparently now would have to increase the Social Security tax almost 100% to maintain the actuarial balance of the Social Security system.

Mills said the quarrel he has with the proposed increased tax in the bill is that it does not take into account future costs and the effect they would have on the fiscal soundness of the overall Social Security System. He said a bill should not give the impression that the aged can get these services at some cut-rate cost, or that the economy and costs will remain static.

"If that is a realistic assumption, then I do not know what an unreal assumption is," said Mills. If such a program is passed, he continued, Congress must face up to the costs and provide a tax in existing law that will take into account future costs.

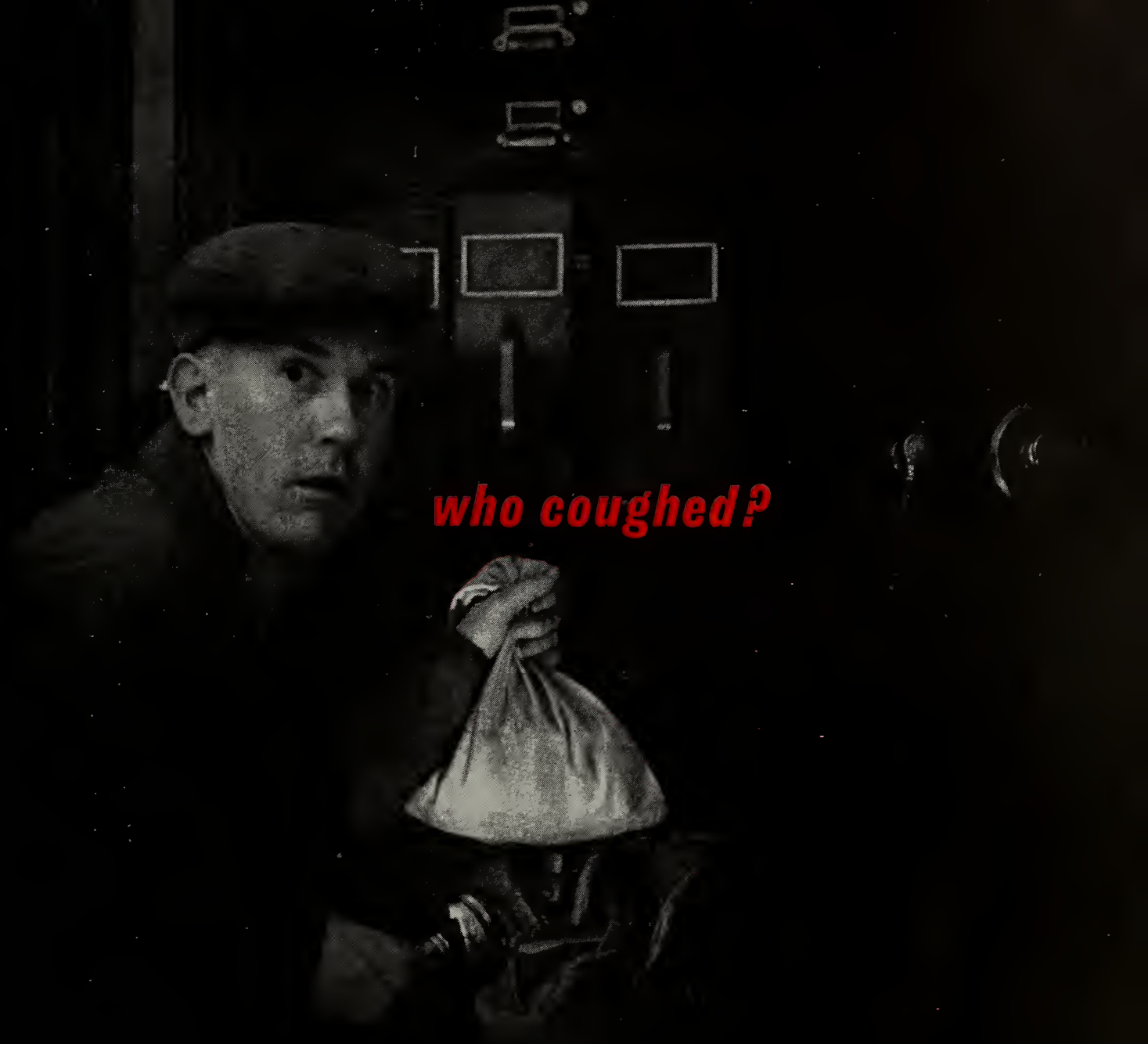
If the King-Anderson bill were enacted with a shaky actuarial basis, Mills said, action by some future Congress would be necessary to raise the taxes to support it, and this might be very difficult.

Mills has introduced a bill to increase the regular Social Security tax and the wage base it is levied on so that the system will be financially in order.

HEW Secretary Anthony Celebrezze told the committee that congressional enactment of the Administration's plan for a hospital-medical benefit program financed by higher Social Security taxes is both "necessary and urgent."

Another major development at the hearings was an attack by Sen. Karl Mundt (R., S.D.) on HEW officials for trying to impede the Kerr-Mills program of federal-state aid for the indigent and medically-indigent

Continued



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elderly.

Mundt declared that Kerr-Mills is the victim of a planned program of interference on the part of the Department of HEW, King-Anderson supporters in Congress, and welfare workers and officials at the state and county levels. He suggested the HEW actions ran counter to the intent of Congress and might be illegal.

PLAN WOULD COST WORKERS TWICE AS MUCH

The president of the American Medical Association told the Committee that the Administration-backed health care for the aged plan would cost the nation's workers twice as much to start as sponsors of the proposal have claimed or would require periodic tax increases to keep it solvent.

Edward R. Annis, M.D., Miami, Fla., surgeon, pointed out that previous testimony disclosed that payroll taxes would have to be increased by one percent, half paid by the workers and half by their employers, and the taxable wage base increased to $5,200 to start the program off on a financially sound basis, or periodic tax increases would be required to keep it out of financial trouble.

The King-Anderson bill (H.R. 3920) calls for a one-half percent payroll tax increase on workers and employers (one-fourth of one percent on each) and an increase in the taxable wage base from the present $4,800 to $5,200 to finance a proposed program of hospitalization, nursing home care and related services to everyone age 65 and over.

Dr. Annis said the King-Anderson bill "would transfer to the federal government at a single stroke the responsibility for the purchase of specified hospital and related benefits for all persons over 65, regardless of their desires or their economic need."

NO JUSTIFICATION FOR USE OF TAX FUNDS

"There is no justification," he said, "for the use of tax funds collected from workers at the low end of the income scale to pay these expenses for the entire elderly population, including the self-supporting and the wealthy."

Dr. Annis declared that actuaries of the Department of Health, Education and Welfare had previously acknowledged in a study of the King-Anderson bill that "periodic tax increases will be necessary in a rising economy to keep the program solvent."

The AMA also pointed out that it has been estimated that it would cost $35 billion for King-Anderson benefits for the aged who would be immediately eligible but would have paid little or nothing under the program. "This is the amount," the AMA said, "that would be necessary to finance health care for the rest of their lives for all those eligible to take part in the program at its start." This figure was confirmed by HEW officials in Monday's testimony.

Norman A. Welch, M.D., Boston, president-elect of the AMA, appeared with Dr. Annis to review "the remarkable contribution toward the financing of health care for the aged that is being made by private health insurance and prepayment plans "which now protect more than 60% of the entire population over 65."

Dr. Annis said, "for years, the American people have been bombarded by such statements as the monthly income of the great majority of the aged is

little more than a Social Security check. Yet, the government's own figures show that the annual income of persons over 65 is $35 billion. Only one-third of this comes from Social Security payments."

"The aged who need help in meeting medical bills are receiving it," Dr. Annis said. He pointed out these developments:

1. Government figures show that more than $1.5 billion in public funds was paid out for this purpose in 1961.

2. More than 10 million persons over 65—over 60% of all the aged—are protected by some form of health insurance.

3. The Kerr-Mills program, including Medical Assistance for the Aged and Old Age Assistance, paid out more than half a billion dollars for health care of the aged in fiscal 1962.

Dr. Annis asserted that King-Anderson type legislation "would impose a permanent pattern of tax-paid, government-regulated health care—a pattern inherently subject to inevitable expansion."

"Such expansion," he said, "would lead to a deterioration of the quality of health care—disrupting the voluntary relationship between the patient and his physician and imposing centralized direction which would frustrate the striving for professional excellence. It would bring about a decline of professionalism and create a form of medicine strange to these shores. It would result in a loss of able entrants into the health care field because of government controls over medicine. We believe that this legislation is not only unnecessary but also dangerous to our American system of medical care."

About Our Cover



It is a well established tradition to make all kinds of good resolutions at the beginning of a new year. It is also traditional that the majority of these ambitious resolves are bent or broken very shortly afterwards! This will doubtless be the fate of the majority of the high resolves of 1964.

But there is one resolution for 1964 that we must all *make* and not *break*—the resolution to work together, with all our energy and to the utmost of our ability, in preparation for the national election in November.

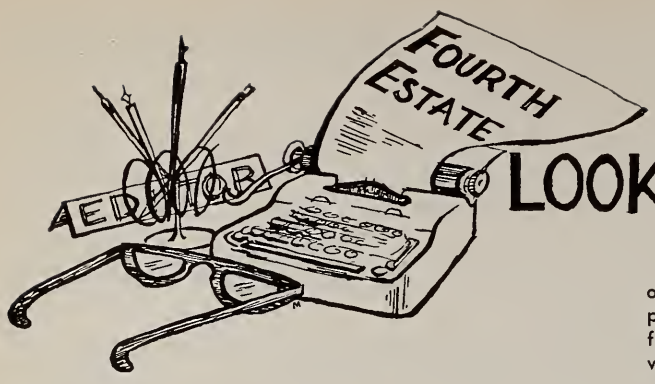
If we truly wish to keep available to the American public the best health care in the world, keep alive our heritage of free enterprise and keep inviolate the freedoms that our forefathers fought so hard to win for us, then it is imperative that each one of us participate actively to prevent any encroachment on these rights and freedoms.

This is no time to think "What difference will it make if I don't work toward this goal . . . just one more or less person can't make any difference to the outcome."

Remember that "For want of a nail the shoe was lost, for want of a shoe the horse was lost, for want of a horse the rider was lost, for want of a rider the battle was lost . . . and all for want of a horseshoe nail!"

We need all the riders we can muster because this is a battle we can not afford to lose.

The picture of the voting machine reproduced on our cover was made available through the courtesy of Ries Equipment Company, Indianapolis—M. E. R.



LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Food: A Weapon

Delegates to the 45th annual Indiana Farm Bureau convention here this week deserve public commendation for putting the national interest above dollar gain. They went on record against sale of farm commodities to Communist countries.

Their resolution coincides with the views of former West German Chancellor Konrad Adenauer, as expressed to a group of United States businessmen in Bonn [Nov. 11]. Eugene N. Beesley, president of Eli Lilly & Co., Indianapolis, was a member of the group.

Adenauer told the Americans the free world should capitalize on the food shortage in the Soviet Union as a weapon in the East-West cold war. He minced no words in telling his visitors Western tactics should follow the medieval system of starving besieged cities into submission.

Calling off the United States wheat deal, of course, would involve no such stark alternative. But it would be a step in the proper direction of increasing—rather than "easing"—the economic tensions besetting the Soviet world.

The former finance minister of Hungary, Dr. Nicholas Nyaradi, told the Farm Bureau the "incredible productivity of our free enterprise system is the only reason why Nikita Khrushchev is talking today about peaceful coexistence."

And Bureau president George Doup cautioned: "If the wheat sales are interpreted as U.S. capitulating to Communism, the price is far too great a payment for modestly reducing the grain surplus, slightly lessening the total tax cost and effecting a minor improvement in the United States balance of payments. In the end, it will not promote our pursuit of peace."

The Washington government should repudiate a deal which has the effect of bailing our mortal adversary out of his self-made difficulties.

American food surpluses can and should be a major part of the arsenal of cold war weapons with which we strengthen our own security by enforcing peace with freedom. —*Indianapolis News,* November 14, 1963.

A Bigger Bitter Pill

The bigger and better compulsory medical care program for the aged which has been proposed by a new study group rests on the same illusion as earlier, less glittering proposals.

The illusion is that government—especially the Federal government—is blessed with some magic which enables it to buy for people things which they cannot buy for themselves. It is true that this can be done for a relatively few selected individuals. But any effort to do it on a general basis must come to grief on one hard fact of reality.

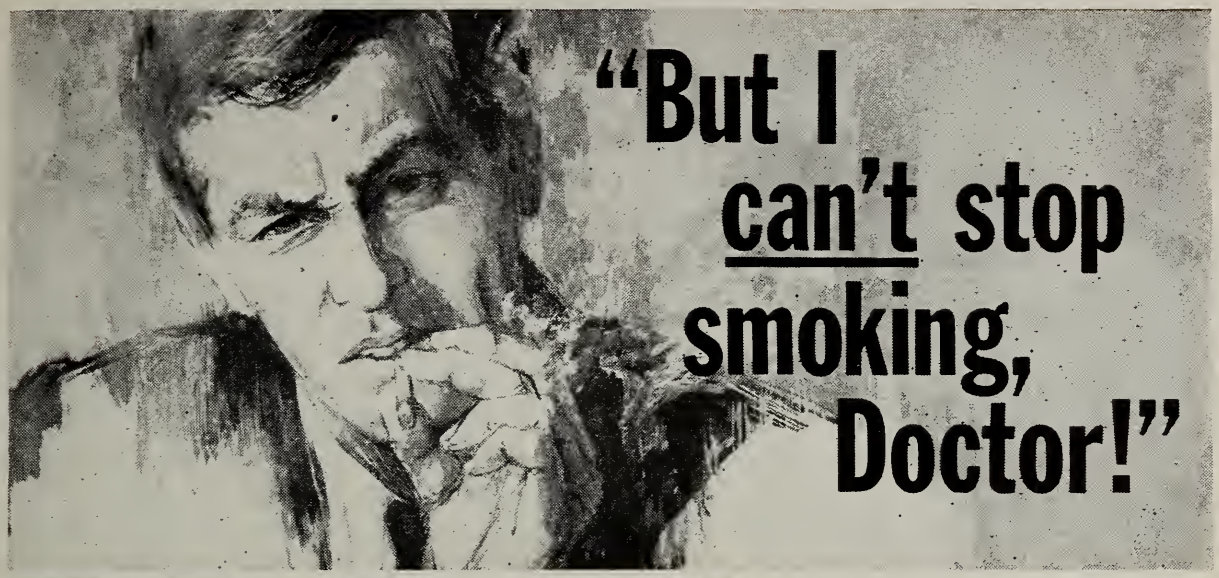
The hard fact is that government has no money except what it gets from the people.

The illusion is compounded by the Robin Hood complex. The idea of redistributing wealth and income by taking from the rich for the benefit of the poor is woven through all these schemes to have government buy things for people they can't buy themselves. Morally right or wrong, it doesn't even apply in many cases, including this one.

This is another medical care proposal to be financed by an addition to the social security tax. This is very definitely not a

Continued

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References: 1. Goodman, L. S. and Gilman, A.: The Pharmacological Basis of Therapeutics, New York, Macmillan, 1960, Ed. 2, pp. 620-622; 2. Edmunds, C. W.: J. Pharmacol. and Exper. Therap., 1:27, 1909; 3. Hazard, R. and Savini, E. Gand., 92:471, 1963. 4. Dorsey, J. L.: Ann. Int. Med., 10:628, 1936; 5. Rasmussen, K. B.: Ugeskr.laeger, 118:222, 1956; 6. Ejrup, B.: Sven. lak. Tid., 53:2634, 1956; 7. Jochum, K. and Jost, F.: Munch. med. Wchnschr., 103:618, 1961; 8. Jost, F. and Jochum, K.: Med. Klin., 54:1049, 1959; 9. Smoking and Health, Summary and Report of the Royal College of Physicians of London on Smoking. New York, Pitman, 1962.

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tax on the rich. Just the reverse. It is paid almost entirely by the working man and woman. It is paid on all of the lowest incomes, on most of an average income, and on a piece of each higher income.

There'd be no Robin Hood in this medical care plan. It would be the wage earners of the nation shelling out to buy for a group of government-selected beneficiaries, something a large number of these same wage earners do not buy for themselves. How many feel they can afford insurance coverage to pay all hospital costs for 90 days? Almost anyone would like to have it, of course. But when there's choice the cost will be weighed against the cost of other things the individual would like to have.

That's why they talk about a compulsory plan. Such a scheme as this one would have to be compulsory, because otherwise a lot of people wouldn't buy it.

Truly stated, the capability of government in this kind of matter is to buy for people—with their money—something they choose not to buy for themselves.—*Indianapolis Star,* November 15, 1963.

Plans For Disaster

Anyone with a grudge against hospitals and doctors just hasn't been paying attention lately.

The hospitals, their doctors, nurses, technicians, orderlies and all the rest did a truly magnificent, miraculous job during the bloody hours of the Coliseum disaster.

One measure of their success is that of the 68 who were killed, fewer than half a dozen died after reaching the city's hospitals.* What makes this record all the more amazing is that the hospitals treated almost 400 injured, more than 100 of them seriously and critically hurt.

The first word of the disaster put in motion never-tried disaster plans at the hospitals. The disaster plan at St. Vincent's Hospital had been rehearsed a few weeks before with a dozen dummy patients. In the first hour, 120 real patients were admitted.

Yet the terrible burden was shouldered without a falter. People lived who might have died had the efficiency been any less.

If there was any faltering, it was at the next level—the level of co-ordinating the hospitalization of the victims. St. Vincent's and Methodist Hospital both were jammed while there were doctors and nurses waiting at Marion County General Hospital.

What was needed was someone at the Fairgrounds to direct the ambulances, cars, buses and taxicabs carrying the injured to the various hospitals so the facilities could be most efficiently used. While General waited, there were reports of ambulances waiting to unload injured at Methodist.

It might be wise to consider the possibility of disaster at each of the city's schools, churches, auditoriums, stadiums—wherever large crowds gather.

It might be wise for some agency—the city police or the state police, for example—to work with the hospitals to devise a plan for getting the injured from each of the places to the hospitals in such a way that no hospital is jammed while others are only partly used.

Again, it might be wise to work out emergency routes from the hospitals to each place where the Coliseum disaster could be repeated. Then police could be dispatched automatically to keep these routes cleared.

And may we all hope and pray that our disaster plans never again are used.—*Indianapolis Star,* November 8, 1963.

*The number of deaths resulting from the explosion has now risen to 73.

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Supervised by THE COUNCIL

Volume 57 — January 1964 — Number 1

Hypnosis: Its Nature, Hazards, and Uses*

JOHN PAUL BRADY, M.D.†
Philadelphia, Pa.

IN DISCUSSING HYPNOSIS, perhaps the most difficult task is to provide a rigorous and yet meaningful definition. It is easier to begin by stating what hypnosis is *not* or what is *non-essential* to a hypnotic state. Hypnosis usually involves two persons; but with training, many individuals can induce hypnosis in themselves. Some hypnotists frequently induce a trance in a group of persons simultaneously.

The usual technic of inducing hypnosis begins with a series of suggestions to the subject that he will become relaxed, drowsy or sleepy. However, this is not essential either. In fact, some highly suggestible individuals who have not been hypnotized previously will demonstrate hypnotic phenomena as the result of simple direct statements. Thus, without any preliminary suggestions, the hypnotist might say, "you cannot raise your right hand" or "you are unable to speak." Such suggestible subjects will make obvious efforts to raise their hands or speak but be unable to do so.

We often think of hypnosis as involving an altered state of consciousness, giving the subject the appearance of being in a fugue or somnambulistic state. However, a dazed or trance-like appearance is not essential to hypnosis and a hypnotized subject may appear fully awake and alert. The changes in facial expression, spontaneity, etc. which we associate with being hypnotized appear largely to be a function of the subject's expectation of what a hypnotized person should look like and how he should act. Mesmer, for example, believed that hypnosis invariably began with generalized convulsions. His subjects shared this belief and indeed they invariably had a fit on entering a trance.

Sensory or Motor Changes

Another approach to the problem is that of requiring that certain phenomena of a motor, sensory, or psychic nature be induced by suggestion before a state of hypnosis is said to exist. One might use as a criterion the induction of hand paralysis, a visual hallucination, amnesia or some combination of these. This approach is limited, however, because of the variability of the hypnotic phenomena which are obtainable in different subjects at different times. Thus an individual may experience visual hallucinations on hypnotic suggestion and yet show no motor alterations such as simple arm paralysis. Contrariwise, an individual may be made amnesic by hypnotic suggestion and yet show no sensory or motor changes.

*Paper read before the Grant County Medical Society at the V.A. Hospital, Marion, Indiana in October 1962.

†From the University of Pennsylvania School of Medicine, Philadelphia.

Finally, one might hope to identify some physiological change, perhaps in the EEG or electrical resistance of the skin, which would indicate the presence of a hypnotic state. Although much effort has been expended in this direction, no physiological change has been identified, as yet, which invariably accompanies the hypnotic state.[5] Furthermore, there are no physiological changes ever induced by hypnotic suggestion which do not occur under some circumstances in non-hypnotized individuals. For example, no electroencephalographic changes have been reported which are unique to hypnosis.

We see, then, the difficulty of a definition of hypnosis, either in terms of the procedure used for its induction, the motor or sensory changes which are produced, or the physiological changes which can be recorded. None of these clearly delineate hypnosis from all other states. However, we can identify some common features of what most persons would consider a hypnotic state. These include a selective attentiveness to the hypnotist's statements, an increased tendency to carry out suggestions—verbal and nonverbal—and an attitude of passive compliance with the hypnotist. Thus, we might define hypnosis as a state of heightened suggestibility with some selective attention to the hypnotist's statements and passive compliance with his directions.

Regarded as a state of heightened suggestibility, it is likely that hypnosis has played a role in medical practices from the earliest efforts of one man to minister to the health needs of another. No doubt the powerful effects sometimes seen in the ministrations of the witch doctor, the Indian medicine man, or, in the past, the King's Royal Touch, depend in part upon the suggestibility of the subject in the particular setting, and involve hypnosis or a closely related state.

Of course the judicious use of suggestion in the wake state plays an important role in modern medicine as well. We are all familiar with the placebo effect. We know that patient improvement is often related to the assurance of the doctor and the faith of the patient that the medicine or therapeutic procedure being used will be of benefit. This is particularly true when the patient-doctor relationship is imbued with warmth, trust and confidence. These are also characteristics which, in general, favor the successful induction of a hypnotic trance and the demonstration of hypnotic phenomena!

In the explicit use of hypnosis this aspect of the doctor-patient relationship—suggestibility—is greatly increased and becomes a very powerful tool. However, with this increased potency comes increased risks. Some of these risks are simply exaggerations of the risks and hazards which always attend the use of suggestion, whether implied or explicit, in treating a patient. Some of these hazards are unique to the hypnotic situation.

Hazards of Hypnosis

There is much controversy about the dangers of hypnosis. I know of only one large study designed to estimate the frequency of significant adverse reactions. Levitt and Hershman[6], using a survey technic, obtained completed questionnaires from 301 professionals who used hypnosis extensively in their clinical practice (70% were physicians, 19% dentists, and the remainder had other professional identifications). More than one out of four of the respondents reported observing an alarming reaction or psychopathological state on at least one occasion in his experience. These ranged from primarily physical symptoms such as headache, vomiting, or fainting, to marked depression or panic states. Over two percent reported having observed frank psychosis following hypnosis.

This survey clearly suggests that hypnosis can indeed be dangerous. As in the use of other medical procedures, however, dangerous untoward reactions can be reduced to a minimum with an adequate knowledge of the technic and the exercise of clinical judgment in its use. The latter requires a minimum knowledge of personality dynamics and familiarity with the individual patient; his expectations, needs, problems and defensive structure.

In considering hypnosis, the physician should always question what hypnosis would mean to the patient in terms of his past experiences, his ideas and attitudes

about hypnosis, and the patient-doctor relationship. This is particularly important when the patient himself originates the idea of using hypnosis for some purpose. In my own experience it is not uncommon for a patient to request hypnosis in lieu of anesthesia during childbirth, for weight reduction, or for some other stated purpose when, in fact, the real purpose is to obtain psychiatric help for some other problem. Sometimes the patient is not consciously aware of his or her underlying motivations for hypnosis.

For example, some disturbed individuals seek hypnosis as a means of escaping from a reality they perceive as intolerable. Hypnosis in this situation may further facilitate flight from the real world into a world of fantasy.

The fantasies which may be inadvertently induced in a subject by the induction of a hypnotic trance are another hazard. Remember that hypnosis is usually induced in a darkened room in which the patient is lying on a couch, has his eyes closed and has an attitude of exaggerated submissiveness toward the hypnotist. These circumstances stimulate intense sexual fantasies in some patients. Hence, there is a hazard of heterosexual or homosexual panic in unstable persons with problems in this area.

If hypnosis is being considered for the amelioration or removal of a neurotic symptom, the question should always be asked, "what role does the symptom play in the patient's defensive structure and what might be the consequences of its rapid removal through hypnotic suggestion?" In general, neurotic symptoms, such as phobias or conversion symptoms, represent defenses against the recognition of unconscious conflicts. Rapid removal of these symptoms by hypnotic suggestion risks disrupting the patient's neurotically compromised adjustment and precipitating severe anxiety, panic or perhaps an even more serious, symptom complex.

This problem is illustrated by patients who seek to reduce their weight through hypnotic suggestion. In some instances the major factor in obesity appears to be a familial or subcultural pattern of overeating. In such a person in whom overeating is not the *result* of a serious neurotic conflict, and who, in general, has a well integrated and mature personality, no great danger exists. However, overeating and obesity may represent the patient's solution to a serious and deep-seated neurosis. Not uncommonly adolescent girls and sometimes older women having problems in the sexual area, overeat out of an unconscious motive to make themselves physically unattractive to men. Thereby they avoid to a large extent the anxiety or guilt-provoking problem of dealing with suitors. In such cases successful dieting and substantial weight reduction may be facilitated by hypnotic suggestions that high calorie foods will produce nausea. However, the basic problem is not solved and the patient's anxieties or guilt may heighten with the development of more incapacitating and serious psychopathology.

Many instances of serious psychopathology have been reported to result from the injudicious removal of a neurotic or psychophysiological symptom by hypnosis, when the personality structure and life situation of the patient was not investigated sufficiently. For example, there have been many instances of frank psychosis precipitated by removal of chronic dermatologic symptoms in disturbed individuals by hypnotic suggestion.

Hypnosis in Modern Medicine

Space will not permit even a cataloging of the clinical uses of hypnotic suggestion. The major areas in which hypnosis is used in medicine will be outlined, however.

1. *To promote relaxation.* One of the simpler and safer uses of hypnosis is the induction of relaxation in tense individuals. Many instances of tension headaches and low back pain due to chronic muscular rigidity can be improved in this manner. An intelligent subject, free of any serious personality disturbance, may be taught to induce light states of hypnosis in himself to supplement relaxation induced hypnotically by the physician. Other conditions such as migraine headache and stuttering, in which a tension cycle seems to be operating, may be safely improved by hypnotically induced relaxation.

2. *The removal of neurotic or psychophysiological symptoms by direct suggestion.*

This is one of the oldest uses of hypnosis but also one of the most dangerous. Sigmund Freud put hypnosis to this use early in his career when attempting to cure hysteria. He soon learned that the simple removal of the symptom was a poor solution to the problem, since hysterical symptoms have a great propensity to return or, if removed, be substituted by other neurotic complaints.

The dangers which attend the rapid removal of a neurotic or psychophysiological disturbance, which is merely the expression of a powerful repressed emotional conflict, have already been mentioned. Under special circumstances hypnosis may justifiably be put to this use. Sometimes the rapid removal of a neurotic symptom is indicated as an emergency procedure, but it should be followed up by other medical and psychiatric technics. In general, however, this use of hypnosis is to be discouraged unless one is sure that the patient has the personality assets and flexibility to readjust to the sudden loss of a neurotic defense.

A related use of hypnosis is the control of a particularly dangerous habit, such as the smoking habit in a patient with thrombo-angitis obliterans (Buerger's disease). Curbing smoking in such a patient by a series of hypnotic suggestions may be indicated when ordinary methods of persuasion have failed. Hypnosis may also be used in some disorders which do not appear to be associated with severe emotional conflict. An example of this is the removal of ordinary warts by hypnotic suggestion.[9]

3. *Abreaction.* This refers to the recovery of the memory of traumatic experiences which had been made amnesic through repression. This method of recovering lost memories, with the release of intense affect associated with them, is often therapeutic in those neuroses in which a single or series of very traumatic events play an important role. However, this use of hypnosis is limited, since most neuroses do not spring from a few traumatic experiences. Further, this procedure necessitates a thorough knowledge of personality dynamics and psychopathology and should be practiced only by those especially trained in psychiatry and related disciplines.

4. *Hypnoanalysis.* This refers to the use of hypnosis to facilitate the recovery of repressed memories, ideas and attitudes in psychotherapy to further the patient's self-awareness and the acquisition of insight. This method was used also by Freud but largely abandoned by him in favor of free association as a means of obtaining repressed material. Recently this technic has been revised as an adjunct to classical psychoanalysis but again the technic is one for the specialist.

5. *Anesthesia.* Hypnotically induced anesthesia is often desirable as an alternative to chemically or thermally induced insensitivity to pain. Major surgical operations have been successfully performed under hypnosis for many years. In fact, their systematic and documented use antedates the extensive use of chemical agents.[3]

There are advantages and disadvantages to hypnotic anesthesia and its choice depends upon the circumstances of the individual case. This usage of hypnosis has been extensively reviewed elsewhere and includes such divers uses as childbirth[4], tooth extraction[8], and craniotomy.[7] Related to the use of hypnosis for surgical procedures is its use for the control of intractable pain, as in terminal cancer.[2]

6. *Other uses.* There are cases reported in which symptoms with a neurological basis have been altered by hypnotic suggestion. For example, Buell and Biehl[1] report the *temporary* abolition of tremor in two patients with Parkinson's disease by hypnotic suggestion. In our own laboratory we studied the effects of hypnotic suggestion on an individual with paramyotonia congenita, using continuously recorded electromyograms. Immersing the hand in cold water produced the typical sustained muscular contraction after the patient attempted to relax the clenched fist. Suggestions that his fist would relax in the wake state had no effect. However, under hypnosis the same suggestions produced a rapid decrease in the amplitude of electromyographic potentials and his hand relaxed.

Applications of this sort, as well as the alteration of other physical symptoms by hypnotic suggestion, have an interest beyond the immediate clinical improvement in

a symptom. This is their possible use in the analysis of the entangled psychosomatic relationship which underlies many medical disorders.

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From the Journal 50 Years Ago

. . . "The relation between the blood pressure and the prognosis in abdominal operations is based on two extremes, viz., an extremely low blood pressure and an extremely high blood pressure. Provided the heart is normal, we can now control the low pressure phase by transfusion of blood, by mechanical means, or by saline solution. The high blood pressure is far more difficult to control because it is difficult to control the factors that produce this condition. If there is cardiovascular disease due to infection or to lues, nitroglycerin may have little effect, though there is a type of cardiovascular disease that is controlled by nitroglycerin. It is not wise to reduce the blood pressure by bleeding, and aside from nitroglycerin and hygienic measures there are no other remedies. Whether the blood pressure be abnormally high or abnormally low, the patient is more likely to have complications, such as thromboses, emboli, pneumonia, nephritis, indeed the abnormal blood pressure plays into the hands of the usual dangers and complications of abdominal operations.

Could the operation be so performed that the nervous system would remain uninjured, the blood pressure unaltered, the maximum degree of safety would be reached. The author* found this could be done on the principle of anociassociation." . . . Thomas B. Eastman, M.D., "Some of the More Important Contributions to Abdominal Surgery and Gynecology During 1913" *JISMA*, January, 1914.

*Crile, *Am. Gynec. Assn.*, 1913.

Report of a Rare And Unusual Case

Human Infection with Canine Whipworm

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KNOWN HUMAN INFECTION with canine whipworm, *Trichuris vulpis* is a rare occurrence. The first apparently recognized case, in 1954, reported by Hall and Sonnenberg,[1] involved a four-year-old Caucasian male living on his grandparents' farm in Maryland. Zoonotic trichuriasis appeared to have been contracted from infected bird dogs kept on the premises. The clinical picture was not described. Treatment with gentian violet was not effective.

Although no additional confirmed cases have been found in an extensive search of the literature, specific references to the occurrence of canine whipworm eggs in human fecal specimens were encountered in two reports. Strongly presumptive evidence of infection was reported in a study by Dinulescu et al.[2] who found *T. vulpis* eggs in stool specimens from 6.10% of 421 male workers, ages 21-23, occupied in the raising of dogs in Rumania. On one occasion both large and small trichurid eggs were observed by Burrows and Lillis[3] in the stool of a patient. A follow-up study of this finding was not made.

This report describes a second confirmed human case of canine trichuriasis, also involving a child, in the United States. The case is of further interest in that it afforded the opportunity to employ the broad-spectrum anthelmintic, dithiazanine iodide, which has been found effective in treating the human whipworm species, *Trichuris trichiura.*[4] The unusual method by which the infection was initially revealed emphasizes the value of a constant vigilance for zoonotic infections.

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Case Report

The patient was a six-year-old white male who had lived all his life at the same residence in Indianapolis.

On October 20, 1962, the child was brought to his family physician, an associate author, with complaints primarily of poor appetite, fecal incontinence, easy fatigability, and intermittant abdominal pain usually after eating. These symptoms had an obscure beginning, with a gradual increase in intensity over a period of approximately six months. The physical examination was non-informative. Hematological tests showed a hemoglobin level of 11.9 grams (79%), a white blood cell count of 11,400 and a normal differential with four percent eosinophils. The patient's past clinical history included a normal intravenous pyelogram, cystoscopy and meatotomy, all performed in 1961, but otherwise was generally unrevealing.

The possibility of a pinworm infection was considered, and a perianal cellulose-tape smear was submitted to the Parasitology Laboratory of the Indiana State Board of Health. This examination was negative for *Enterobius* eggs or worms; however, three eggs with the measurements and morphology of *T. vulpis* were found embedded in small masses of fecal detritus. A stool specimen examined several days later contained the large trichurid eggs in relatively moderate numbers. The eggs measured from 78.4 × 35.2 to 84.8 × 41.6 microns (M = 80.9 × 37.0) and their morphology was typical for *T. vulpis.* (Eggs

of the human whipworm, *T. trichiura*, are morphologically similar but considerably smaller, measuring 50 × 22 to 54 × 23 microns (Figures 1, 2.). No other parasites were found.

With this presumptive evidence of a canine trichurid infection, therapy with the broad-spectrum anthelmintic, dithiazanine iodide (Delvex*), was begun. The dosage prescribed was 50 mg. q.i.d. the first day and 100 mg. q.i.d. for four additional days.

The first post-treatment stool was examined two and one-half weeks following completion of therapy. Contrary to the anticipated results, *T. vulpis* eggs were still present, with no apparent reduction in the worm burden. It was then decided to repeat chemotherapy with the same anthelmintic, but with some modifications. Unfortunately, at this time the parents did not reveal that the child had actually received only the approximate equivalent of one day's dosage because of difficulty in administering the enteric coated tablets. This fact was learned in retrospect, after the completion of the second and longer course of therapy.

The repeat dosage was 50 mg. q.i.d. the first day and 100 mg. q.i.d. for nine additional days. In an attempt to facilitate contact between the drug and the worms, the enteric coating of each tablet was ruptured and the crushed tablets given the patient in small amounts of applesauce. No untoward reactions occurred with this treatment.

When the patient was next seen, about five weeks later, he was generally improved, abdominal pain and fecal incontinence had disappeared, and the appetite had returned. Stool specimens were checked for eggs at intervals of approximately two, seven, and 12 weeks after completion of the second course of therapy. No eggs were found in any of these specimens, all of which received comprehensive examinations, and it was felt that the treatment had been successful.

The patient has remained asymptomatic for a period of at least six months following completion of therapy.

Probable Source of Infection

Detailed information on animal contacts was obtained from the patient's father. From ambulatory age until the spring of 1962, approximately six months prior to discovery of the infection, the child was continually associated with dogs kept on the premises where he lived. Canine contact of a quite casual nature resulted from periodic visits to the maternal and paternal grandparents' farms in Perry County, Indiana. Other animal contacts were negligible.

Two excessive associations with dogs and their environment were apparent, the first

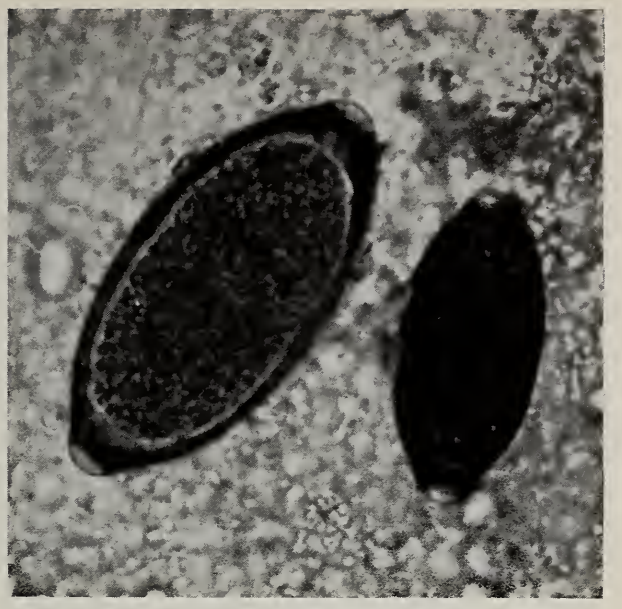


FIGURE I

COMPARISON of Trichuris vulpis (larger) and Trichuris trichiura (smaller) eggs from dog and human, respectively.



FIGURE II

CANINE and human whipworm eggs as they appear in a microscopic field with the low power objective.

*Eli Lilly and Company, Indianapolis.

occurring when the patient was two to three years of age. At this time the child exhibited an intense fondness for a pair of English springer spaniels acquired by the father, often playing for an hour at a time within the dog house itself. The second salient contact involved a strong affection for a female bird dog and her litter of 12 pups during the spring of 1961, about a year before the patient became vaguely symptomatic.

According to the father, none of his dogs had ever been treated specifically for trichurids or examined by a veterinarian. The English springers had never been given any vermifuge; however, the bird dog and her offspring had been wormed with one of the non-prescription anthelmintics sold in drug stores. By the spring of 1962, all animals had been removed permanently from the premises and none were available for parasitological examination.

Discussion

The patient discussed in this report appeared to have an uncomplicated canine whipworm infection. No other intestinal parasites were found, nor was any other cause for the symptoms determined. An established infection was evident from the finding of the large, characteristic *T. vulpis* eggs in repeated specimens from the child, more than six months after the removal of all dogs from the premises.

The clinical picture has been presented as it was observed. Although the syndrome was generally non-specific—a frequent characteristic of intestinal helminthiasis —it is of interest in that it is apparently the first reported case of this infection in man. With regard to the therapeutic efficacy of dithiazanine iodide, one can only conclude that the second regimen, as administered, apparently effected a cure. It is entirely possible that the initial treatment, had it been taken by the patient as prescribed, also would have expunged the trichurids.

Significant animal contact appeared limited to those dogs kept by the patient's family. Although none of these animals were available for examination, it is highly probable that one or more harbored *T. vulpis*. This species is a common canine parasite in the Midwest. Parasitological data compiled by an associate author[5] on 15,425 mongrel dogs from the Ohio River Valley region for the years 1958-62 showed an average of 61% infections, with an annual range of 55-65%.

While it was not possible in this case to incriminate any one dog, the excessive opportunity for exposure resulting from the patient's affection for the English springers and for the bird dog and her offspring points to these animals as sources of infection. Interestingly enough, two other children in this family, a five-month-old male and a five-year-old male, neither of whom showed any evidence of infection, had not been closely associated with these dogs.

Evidence of the importance of dogs as potential sources of zoonotic infections increases each year. The second report of the Joint WHO/FAO Expert Committee on Zoonoses lists 13 prevalent helminth diseases, involving eight trematode, two cestode and three nematode species, for which the dog is an important animal link in the chain of infection to man.[6] This list excludes the many sporadic case findings of unusual invasion by other species of animal helminths. However, it is to be expected that some of these latter human-animal disease relationships now being found will in the future emerge as new and important zoonoses, ultimately to be included in the above list.

Alertness to the potential of any animal parasite as a human invader is a prime factor in new incriminations of helminths and their animal hosts. Single case findings may stimulate a search for other occurrences. Often, as in the case of *T. vulpis* and *T. trichiura,* the morphological differences between those helminth species parasitic for man and other related species parasitic for lower animals are minimal. At times, clinical features may be of little value in resolving a diagnosis, and the only visible clue may exist as an incidental finding in laboratory examinations. In this case the detection of only three trichurid eggs almost hidden in the detritus of a perianal cellulose-tape smear, during a search spe-

cifically for pinworm eggs, emphasizes the value of a constant vigilance at all times for the unusual.

Summary

A human case of canine whipworm infection is described. It is the first such case reported from Indiana and the second confirmed case reported from the United States. Definite clinical symptoms were attributed to the presence of trichurids. The patient was successfully treated with dithiazanine iodide. Family dogs were implicated as the source of infection.

That *T. vulpis* can infect man was initially shown by Hall and Sonnenberg[1] in their report of this infection in a child. Presumptive evidence was contributed by Dinulescu et al.[2] and Burrows and Lillis[3] in their reported findings of eggs in human fecal specimens. The authors present this report of a second confirmed case of canine whipworm infection in man as additional evidence for suspecting *T. vulpis* as potentially an important human parasite.

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Professional Dignity

. . . The moral dignity of the medical profession arises from adaptation to human wants and necessities. Ever since disease has been the appointed inheritance of man, the varied ills that flesh is heir to has called forth aid and sympathy for their alleviation and removal. The demands of society are competent skill and qualification.

The men of our profession who have voluntarily devoted themselves to this work, have with a genuine spirit of self denial, entered the world's great "Lazar house, where despair busily tended the sick from couch to couch, and over all triumphant death held high his dart, but delayed to strike." . . . E. Deming, M.D., *"Address of the President before the Indiana State Medical Society,"* May, 1854.

Methods and Applications of Zone Electrophoresis

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ZONE ELECTROPHORESIS is a general term embracing a number of technics in which the electrophoretic separation is carried out in a solid or semisolid support medium, in contrast to the entirely liquid system employed in the classical Tiselius method. Why should any but those actively engaged in laboratory medicine be interested in such a technical procedure? The answer is to be found in the recent development of increasingly simpler and more productive methods, some of which are practical for the smallest laboratory or even for office practice.

This recent renewal of interest in zone electrophoresis resulted from the realization that the paper strip method, the best known of the zone technics, probably had been evolved to its fullest extent and yet was not wholly satisfactory. Further, it was apparent that the alterations observed in the serum protein fractions separated by the filter paper method were not as much diagnostic help as it had been hoped they would be originally. The purpose of this brief review is to bring to the attention of the general medical reader some of the newer laboratory technics that may be available to him, and perhaps to clarify some of the terms associated with them.

Methods

Filter Paper Strips. Separation of serum proteins or of the different types of hemoglobin on buffer-soaked strips of filter paper has been such a popular technic since its introduction less than 15 years ago that most physicians are probably familiar with this method. The apparatus may be fairly elaborate or a simple homemade set-up consisting of little more than two glasses serving as electrode vessels with the paper strips supported between them. The source of electric current, likewise, may be a complete power supply with many possible modalities or one easily constructed and costing only a few dollars.[6] The amount of serum required ranges from 0.01 to 0.2 ml. and an average run at 150 volts may take six to eight hours. After the separation is complete, the strips are dried and stained to reveal the protein fractions as colored spots or bands distributed along the strip. These bands are usually quantitated by passing the strips through a photometer.

Despite its great usefulness and many applications,[9] interest in paper electrophoresis as a clinical tool has diminished in the last several years. Not only has the lack of pathognomonic changes in the electrophoretic pattern of serum proteins been discouraging, but the separation of the individual fractions on filter paper is not as sharp as one would wish. This blurring of the outlines of the dyed bands is partly due to the fibrous nature of the cellulose itself but also because of the adsorption of albumin by the paper. Since albumin precedes the other fractions, it leaves a thin trail of protein on the paper over which the globulins must migrate. This "tailing" of the albumin adds to the background color of the dyed strip and causes the percentage of albumin to be artifactually low while the globulin values are correspondingly increased.

Cellulose Acetate Membrane. The cellulose acetate strips used for this method are made from the same type of material as that employed for many years as filter membranes in microbiology. The general technic of using the strips is much the same as with paper strips except that the acetate membrane is somewhat more difficult to

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handle. The advantages of this material over paper are that the background is transparent and colorless and the dyed protein bands are sharply defined since there is no adsorption of albumin. Since the definition is much sharper, the protein bands do not have to be so widely separated so that runs of only one or two hours are feasible. Samples as small as 0.0001 ml. can be used. A further advantage of this method is that the strips can be used directly for immunoelectrophoresis, which will be discussed later.

Agar Gel. A thin layer of agar is allowed to gel on a solid support such as a glass plate. A convenient method for small-scale work is to use ordinary microscope slides. A recent modification employs movie film leader strip which is firm yet flexible enough to fit into some of the commercial equipment originally made to accommodate paper strips.[1] After the agar has gelled, the sample is added either in a small hole in the agar or by soaking a sliver of filter paper in the sample and applying it to the gel. After separation is complete, the plates are dried and stained.

Since agar is a large-pore gel, it exerts no retarding effect on the migrating molecules of protein. The number of fractions, therefore, and the order of migration are the same as when paper is employed; that is albumin, alpha$_1$ globulin, alpha$_2$ globulin, beta globulin, and gamma globulin. In agar, as with cellulose acetate, there is no tailing of the albumin and the spots are sharply delineated from the clear background. The major advantage of the agar gel method, however, is that it is the basis for the very useful technic of immunoelectrophoresis.

Immunoelectrophoresis. This method was developed from the well-known Ouchterlony-Elek diffusion technic in which an antigen and its antibody are placed in separate holes made in a slab of agar and allowed to diffuse through the agar toward each other. At the point where the two substances meet, a line of opaque precipitin will be deposited. By using several different antibodies simultaneously, unknown materials can be identified. This approach is applied to electrophoresis by performing the usual separation of protein fractions in agar gel. A narrow trench is made in the gel parallel to the path of the serum and a short distance from it. This trench is then filled with antiserum prepared against any or all of the proteins present in the original serum being analyzed. Alternately, a thin strip of filter paper soaked in antiserum can be laid along the path of migration instead of making a trench. The diffusion of the separated fractions and their specific antibodies in the antiserum forms arc-shaped lines of white, opaque precipitate. These lines can be accentuated by staining.[10] A similar procedure can be carried out using cellulose acetate membrane instead of agar gel.

By this means the five or six fractions separated from serum by paper or agar gel electrophoresis can be shown to consist of a number of components so that 25 to 30 individual fractions can be demonstrated. Most of this increase in complexity occurs in the alpha$_2$-beta region of the pattern. By the use of specific antibodies, such minor fractions as ceruloplasmin, the transferrins, and the haptoglobins have been demonstrated in this zone.

Starch Gel and Acrylamide Gel. These two technics are considered together because they give similar results. Unlike agar, these gels are very finely porous so that as the protein molecules migrate through them, the gels exert an impeding action. Thus the proteins are separated not only by differences in electrophoretic mobility but also by ultrafiltration. The result of these combined actions is that more than 20 fractions can be distinguished. The ultrafiltration effect produces an essential difference between the patterns obtained with these gels and those considered thus far, in that the order of migration is not the same as when paper or agar are used. For example, the filtering action causes some of the alpha$_2$ components to be widely separated, with some of them migrating more slowly than the beta fractions. The great advantage of these gels is that the alpha$_2$-beta zone is "opened up" and hitherto unrecognized components can be studied in detail.[5] From a practical standpoint acrylamide gel is much easier to use than starch gel. The latter method should not be confused with the starch *block* tech-

nic in which granules of starch are simply compressed into a block which acts much as cellulose does.

Applications

No attempt will be made to discuss all of the multitude of applications of these various technics that have been made in clinical medicine as well as research. Rather, a few examples will be given to indicate some of the directions in which interest is developing.

Serum Proteins. There is probably no pathognomonic abnormality in the electrophoretic pattern of the serum proteins with the possible exception of cases of hypogammaglobulinemia and even this pattern can be mimicked in some instances of nephrosis. Certain general changes have been recognized, however, such as a decreased amount of albumin with an increase in gamma globulin in cirrhosis. In nephrosis the albumin is also decreased but the $alpha_2$ globulin is usually increased while the gamma globulin is decreased. The gamma globulin peak is usually increased in the so-called collagen diseases, while in sarcoidosis the globulins tend to increase in step-wise fashion from $alpha_1$ to gamma. It has been repeatedly demonstrated that the abnormal "M" globulin peak characteristically found in cases of multiple myeloma may occur at any point in the globulin region of the strip. Electrophoresis of serum proteins as usually carried out on paper or in agar gel is, then, of limited diagnostic value.

Special, Genetically-Determined Serum Proteins. As indicated previously, the starch and acrylamide gel methods have demonstrated a multiplicity of components in the $alpha_2$-beta region and have opened up a whole new field of investigation. Several of the new bands in the $alpha_2$ zone have proven to be *haptoglobins,* proteins that combine with hemoglobin in the plasma. Different individuals have different combinations of these proteins and the particular grouping is determined genetically. So far four such genetic patterns have been recognized and sera can be typed accordingly.[4]

Iron is transported in the blood by a specific protein, *transferrin* or siderophilin, that migrates in the beta zone. It has been shown recently by starch gel separation that there are at least eight transferrins that occur in different combinations in different persons.[2] The patterns are determined genetically as in the case of the haptoglobins. A third group of genetically controlled proteins has been designated the *G_c group.*[5] On the basis of only these three groups thus far recognized, it can be seen that the genetic typing of sera promises to be extremely complex. Over 300 types have already been identified although only relatively few are at all common.

The practical importance of these discoveries is that while the larger number of fractions produced by these gel methods may renew our hope that some distinctive alterations may be found in various diseases, a great deal of work will have to be done to determine the naturally occurring variations in these genetically controlled groups. Until this is accomplished it will be impossible to tell whether a given pattern is a significant abnormality or merely a normal variant.

Serum Enzymes. Damaged tissues release enzymes into the circulating blood where they may be identified and assayed, e.g., the transaminases. The agar gel methods using either glass slides or film leader strip is well suited to this type of study. One example is the determination of the serum lactic dehydrogenases, of which there are five. The distribution of these five isoenzymes varies from tissue to tissue so that by establishing the pattern of occurrence of the individual isoenzymes in the serum, the site of origin, i.e. the damaged tissue, is indicated. In this way a distinction can be made between a myocardial and a pulmonary infarct.[3]

Hemoglobins. Zone electrophoresis is the method of choice for identifying the types of hemoglobin, although some of the more than 20 varieties migrate so closely together that chemical or ion-exchange methods must be used to distinguish between them. Paper electrophoresis has been very useful in this field but the new technics are proving to be even more helpful by separating some of the established types into still further divisions. Type A hemoglobin,

for example, gives at least three fractions in agar gel.

Cerebrospinal Fluid. The electrophoretic pattern of the proteins of the cerebrospinal fluid follows in general the pattern of the serum proteins except that there is usually a small fraction that migrates ahead of the albumin. In some cases there are two such pre-albumins. The beta peak is usually split in the cerebrospinal fluid whereas it usually is not divided in the serum. In starch and acrylamide gels two abnormal gamma fractions have been observed in patients with multiple sclerosis. One of these fractions seems to occur only in multiple sclerosis but in only about one half of the cases.[7]

The major problem in the study of cerebrospinal fluid is that the amount of protein is usually so small that the material must be concentrated by dialysis or evaporation or a combination of operations before electrophoresis can be accomplished. The same is true of urine. Not only does this process consume a great deal of time but there is always the chance that the proteins may be altered in some way during the preparation.

"Disc" Electrophoresis

This technic is discussed separately because it introduces a new principle that promises to solve the problem of concentration and at the same time offers all of the advantages of the acrylamide gel method.[8] The polyacrylamide gel is formed in a small tube open at both ends. At one end, a gel of different porosity is formed so that when the sample passes through this "spacer" gel the protein constituents are concentrated into a narrow zone at the interface between the two gels. As the current passes through the tube, the components migrate into the main gel and are separated into sharply defined, thin layers. Since the tube is round, these layers are disc-shaped, hence the term "disc" electrophoresis.

The number of fractions and their order of migration is the same as that in ordinary starch or acrylamide gel electrophoresis so that some 20 or more fractions can be obtained. The great advantage of this technic, of course, is that dilute materials such as cerebrospinal fluid can be analyzed directly without preliminary concentration.

Summary

1. Not many advances have been made recently in paper strip electrophoresis, the best known form of zone electrophoresis. The newer methods, however, were developed on the foundations laid by work with this technic.

2. The agar gel and cellulose membrane methods made possible the development of immunoelectrophoresis, the most sensitive technic currently available for the demonstration and identification of protein components.

3. Starch gel and acrylamide gel methods, together with immunoelectrophoresis, have demonstrated the existence of a complex system of genetically determined serum types, the range of normal variants of which remains to be determined.

4. A new development, "disc" electrophoresis, concentrates dilute solutions as electrophoresis is being carried out, allowing the direct analysis of cerebrospinal fluid and urine without preliminary concentration.

5. These new methods are bringing about a reawakening of interest in zone electrophoresis, both as a research tool and as an aid in clinical diagnosis.

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The Wind of Change

There can be no permanent solution to the many problems of medical care. Fifteen years after the creation of the N.H.S. [National Health Service] it is clear that there are deep-seated misgivings in all sections of the community and in the profession.

On every side the question is asked, "What can we put in its place?" There are many ways in which the Service can be modified from within but radical change will require structural alteration in the Act. There is no lack of material for study but the difficulties are two-fold, political inertia and professional timidity.

The profession must lift its head from the interminable and unrewarding study of things as they are and look outwards to other methods, other habits. It should look to changes in the practice of family medicine, in the relationship between doctor and patient, between the hospital and non-hospital doctor. We must look for ways to encourage local enthusiasms and to rejuvenate medicine in an environment of individual, independent and responsible medical practice.

We believe that the present structure of our health service will produce a decline in the quality of the nation's medical care. If the political parties, by a refusal to change, perpetuate this system, it will be a disaster for British medicine and the British people, and, in time, a disaster for the political parties themselves. Reprinted from *Fellowship for Freedom in Medicine,* October, 1963.

Idiopathic Hemochromatosis Treated by Repeated Phlebotomies

Report of Two Cases

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IDIOPATHIC HEMOCHROMATOSIS is a relatively rare disease characterized by an insidious onset and a gradually progressive course, anatomically characterized by extensive deposits of iron pigment in practically all of the parenchymal cells of the body. In later stages, attended by fibrosis of the liver and pancreas and evidence of hepatic dysfunction and diabetes, the disease has often been referred to as bronze diabetes because of the peculiar tinting of the skin by the iron pigment and the associated occurrence of diabetes. Cardiac failure with arrhythmias often occurs, and gonadal atrophy with loss of pubic and axillary hair is also frequent.

At present Sheldon's[1] theory of an inborn error of the iron metabolism appears the most acceptable. This defect is present in all the cells of the body and causes an increased avidity of all tissues for iron.

Granick[2] demonstrated that iron normally is absorbed from the gastrointestinal tract in the region of the duodenum and, more specifically, in the area just distal to the pyloric sphincter. He stated that the ingested iron becomes bound to a protein acceptor, called apoferritin, which is present in limited amounts in the intestinal mucosa. The combined form, known as ferritin, releases the iron to the plasma; then the apoferritin is again capable of combining with ferrous iron. Granick[3] also postulated that the apoferritin—ferritin system regulates the absorption of iron from the gastrointestinal tract by blocking further iron uptake when all the available apoferritin is combined with iron, thus in hemochromatosis there appears to be a breakdown in the normal iron absorption mechanism, and there is an increase in iron absorption through failure of the apoferritin—ferritin blocking mechanism in the duodenum mucosa.

The normal body content of iron totals three to five grams. This may be divided into four parts.[4]

A. Red cell iron constitutes the largest fraction, 1.5 grams to 3.0 grams.
B. Storage iron represents excess iron in the soluble form as ferritin, or in the insoluble form as hemosiderin, deposited as iron salts in a protein matrix. This accounts for 1.0 grams to 1.5 grams.
C. Body tissue also contains a group of iron pyrol protein complexes such as myoglobin, cytochrome and catalase which represents a total of .1 and .3 grams. There is no increase in these compounds beyond tissue needs.
D. Plasma iron represents the connecting link between the various tissue iron compartments of the body.

Plasma iron is bound to Beta 1 globulin and is referred to as siderophilin.[3-5] Normally, the iron binding protein is one-third saturated with iron. In iron deficiency states the saturation is decreased. Although the concentration of the iron binding protein in the blood is not changed in hemochromatosis, the percentage of the protein saturated with iron is very high. Houston and Thompson[6] find it to be approximately twice as high in patients with hemochromatosis as in normal cases. The normal plasma iron content is about 3 to 4 mg. of iron in transport at any one time. There is a complete turnover of plasma iron in the body every three hours.

In patients with hemochromatosis, the

*From Reid Memorial Hospital.

amount of iron in the red cell mass and in the tissue complexes is essentially the same as in the normal individual, but storage iron, predominantly in the form of hemosiderin, is vastly increased, usually up to 25 grams and frequently up to 50 grams.

The disease or the term "idiopathic hemochromatosis" therefore refers to a general increase in the body iron stores with resultant tissue damage. Idiopathic hemochromatosis is observed about ten times more frequently in the male than in the female —90.4 to 9.6—according to Finch and Finch.[7] The obvious explanation for this sex difference would be the ability of the female to unload iron in considerable amounts through menstruation, pregnancy and lactation. The average woman loses in a lifetime 10 to 15 grams of iron through menstruation alone.

Diabetes a Frequent Symptom

About 70% of all patients with idiopathic hemochromatosis[8] develop the first symptoms between the ages of 40 and 60 years. If symptoms become apparent at a very early age—20 to 30 years—the subjects are more likely to experience manifestations relating to skin, secondary sexual characteristics, such as gonadal atrophy, loss of pubic and axillary hair, and also arrhythmias manifested by cardiac failure. The aged will more often complain of abdominal pain associated with liver neoplasms secondary to cirrhosis.

The initial symptoms most frequently encountered are those related to the onset of diabetes. It is probable that diabetes contributes to the development of weakness, lassitude and weight loss that occurs in well over half of the cases recorded.[8] Approximately 95% of the patients develop weight loss while 70% complain of lassitude and weakness. There is evidence that the liver is the first tissue to be damaged by hemochromatosis.

Ninety-two percent of patients demonstrate hepatomegalia, but more than half of the patients with hemochromatosis show little or no evidence of functional impairment of the liver, in spite of hepatomegalia and proven fibrosis. The liver manifestations of idiopathic hemochromatosis are characterized by gradual progression without acute exacerbations. Loss of body hair, palmar erythema, testicular atrophy, gynecomastia, and particularly loss of libido are often seen and are related to the severity of the liver damage.

About 82% of all patients with idiopathic hemochromatosis develop diabetes mellitus and complain of some of the symptoms of uncontrolled diabetes during the course of their illness. The diabetes may appear rather suddenly and insulin requirements may increase rapidly in the early stages. In most cases however, the diabetes can be controlled with little difficulty. Excessive skin pigmentation is present in 90% of the patients by the time the diagnosis of hemochromatosis is established. Where iron deposits have occurred, a metallic gray hue is observed.[11]

The most important manifestations of heart disease in hemochromatosis are those of congestive failure and cardiac arrhythmias. The disorder of cardiac rhythm shows a striking predilection for the younger subjects. The importance of cardiac failure as a complaint of iron storage disease is emphasized by the fact that it constitutes the leading single cause of death in idiopathic hemochromatosis.

Therapeutic Phlebotomy Program

Treatment of idiopathic hemochromatosis[9-11] involves, first, removal of the increased body iron, and second, supportive treatment of the specific organ damage. It was first suggested by Balfour that the course of the disease might be favorably affected by repeated phlebotomies in an attempt to reduce the body content of iron. Later studies by C. A. Finch[8] and his associates demonstrated with the use of radioactive iron that the tissue stores of iron, whether in the form of ferritin or of hemosiderin, were in equilibrium with the hemoglobin iron of the red blood cells and either were readily called upon when available when iron was required for hemoglobin formation.

Ample evidence has now been obtained to indicate that patients with idiopathic hemochromatosis are able to mobilize rapidly the excess stores of body iron by repeated phlebotomies. A weekly phlebotomy over a period of one year may remove as much as

10 to 13 grams of iron from the body stores. The average amount of iron in a patient with hemochromatosis is approximately 25 grams, so that two years of weekly bleeding will be required to deplete the excess stored iron. Before undertaking a therapeutic phlebotomy program, a liver biopsy by needle aspiration should be obtained for direct morphologic evidence of the status of the liver and its iron stores. It has been proven that protein will be rebuilt rapidly, and there is no significant alteration in the albumin or globulin concentrations with weekly bleedings; therefore the plasma proteins will be replaced rapidly.

The indication of approaching exhaustion of the iron stores during phlebotomies will be a gradual fall in the serum iron concentration several months before the onset of anemia. A repeat biopsy at this time is desirable to verify the depletion of the iron stores and to exclude the possibility of neoplastic changes.

Case History #1

A white male, age 51, was admitted to Reid Memorial Hospital on May 28, 1954. Chief complaints at the time of admission were chills and fever, chest pain, rectal pain and inability to pass urine. The patient had not felt well for two days. When he got up on the morning of admission he was feeling quite ill, with pain in and around his rectum and buttocks. The pain increased as the day wore on until it became so severe that he could hardly walk. The patient stated he had been constipated for the past week and had noticed some seeping about his rectum but the severe pain did not start until the day of his admission to the hospital.

About ten years ago, the patient had been hospitalized for chest pain but no specific cause was ever established. He had had no other serious illnesses in the past.

The patient's mother died of old age; his father of kidney trouble. He had one sibling living and well. The patient was married, but had no children.

The patient had maintained his weight; his appetite had been good. He had noticed no skin changes nor ankle edema.

Physical Examination:

Examination revealed a well developed, well nourished, white male, who appeared acutely ill. Patient was writhing with pain, and complained of pain about the rectum. His complexion was flushed. His weight was 151 pounds. The tongue and mucous membranes appeared dry. There were rales in the base of the right lung and dullness to percussion. The blood pressure was 100/70. The pulse rate was 88/min. The abdomen was exquisitely tender in both lower quadrants with marked muscle spasm over the whole of the abdomen. There was some blood seen about the anal canal. There was some induration and swelling about the anal region; manipulation and palpation of the rectum caused excruciating pain. The skin was dry and hot. The temperature was 100 F. at the time of admission. The admitting diagnosis was a perirectal abscess and right lower lobe pneumonia.

Laboratory Examination:

Hemoglobin	15.1 gm/100 ml
Hematocrit reading	50%
Differential:	
Stabs	9
Segs	69
Lymphocytes	15
Monocytes	6
Urinalysis	Normal
Serum electrolytes	Normal
Blood culture	Normal
Stool culture	Normal
NPN	30.8
Cephalin flocculation	Normal
Urine for porphyrins	Normal
Thymal turbidity	Normal
Serum albumin	3.25 gm/100 ml
Serum globulin	3.70 gm/100 ml
S.T.S.	Negative
Alkaline phosphatase	13.8 units
Glucose tolerance curve:	
Fasting	115 mg/100 ml
1/2 hour	180 mg/100 ml
1 hour	259 mg/100 ml
2 hour	225 mg/100 ml
3 hour	185 mg/100 ml
BSP	Eight percent of dye retained in 30 minutes
	Two percent of dye retained in 45 minutes

Biopsy of the liver was obtained by needle puncture. Microscopic examination showed

the liver to be the site of a portal cirrhosis. Pigment was very prominent in the liver cells and in the connecting tissue of the portal triads. This pigment did not appear to be bile but appeared to be an iron staining pigment, probably hemosiderin or a similar substance. The microscopic picture was that of hemochromatosis.

X-ray examination of the chest at the time of admission showed a diffuse pneumonitis involving the lower right lung field. Barium enema and upper gastrointestinal series were normal.

Discussion:

When this patient was admitted to the hospital he was acutely ill. He had a perirectal abscess and spiked a temperature of 103 to 104 F. for several days. The patient developed a diffuse pneumonia involving the right lung which further complicated his illness. The pneumonia responded quite well to chloramphenicol. When it was possible to examine his abdomen without muscle spasm, his liver was found to be three fingers below the costal margin. At this time a liver biopsy was done (Figures 1, 2, 3), and a diagnosis of hemochromatosis was established.

The patient has been continued on an extensive therapeutic program with repeated phlebotomies and in the past eight years has had 205 pints of blood removed. We have attempted to keep his hemoglobin level between 10 and 11 grams. He has done remarkably well. His liver has gone back to normal size. Repeat needle biopsy on 1-4-60 has shown almost no iron pigment in the liver and there has been a marked decrease of the cirrhotic changes that were seen previously in the liver (Figures 4, 5). He shows no signs of developing diabetes. A glucose tolerance test was done on January 22, 1963, with the following results:

Fasting glucose	110 mg/100 ml
1/2 hour	150 mg/100 ml
1 hour	162 mg/100 ml
2 hours	173 mg/100 ml
3 hours	130 mg/100 ml
4 hours	135 mg/100 ml
5 hours	79 mg/100 ml

Urinary glucose	Negative
1/2 hour	Negative
1 hour	Negative
2 hours	Negative
3 hours	Negative
4 hours	Negative
5 hours	Negative

Iron studies done on January 22, 1963, showed the following results:

Serum iron	16 ug./100 ml
Total iron binding capacity	332 ug./100 ml
Percent of saturation	4.8

The serum iron was low, and it would indicate that the iron stores were well depleted. The patient offers no complaints. He has been able to maintain his job without any loss of time.

Case History #2

A man, age 61, was admitted to the Reid Memorial Hospital on December 1, 1958, for a needle biopsy of the liver at the request of his family physican. Complaints at the time of admission were nervousness, dryness and discoloration of the skin and sugar in the urine. The patient had noticed a progressive trembling of his hand when he tried to perform fine movements. He also had noted his skin getting darker and appearing "dirty." He had not consulted a physician about these symptoms but during Diabetic Detection Week in the spring of 1959, he was discovered to have sugar in his urine and a high blood sugar. At that time he started on Orinase for his diabetes but it proved uneffective; his diabetes became progressively worse and he was hospitalized on November 16, 1958, and finally was stabilized on 25 units of NPH insulin daily. Laboratory work at that time suggested that the patient had liver disease associated with his diabetes, and an elevated serum iron. The patient was then transferred to this hospital for a needle biopsy of the liver. The patient had lost 45 pounds of weight in the last eight years.

He had a hernia operation in 1937. In 1954 hemorrhoid surgery was done with the removal of a polyp.

The patient's mother died of a goiter at 52; his father died at age 68, cause undetermined. The patient had two sisters living, one was diabetic. The patient was married and had three children all living and well.

The patient complained of moderate dyspnea. His appetite had been good in spite of the fact he had continued to lose weight.

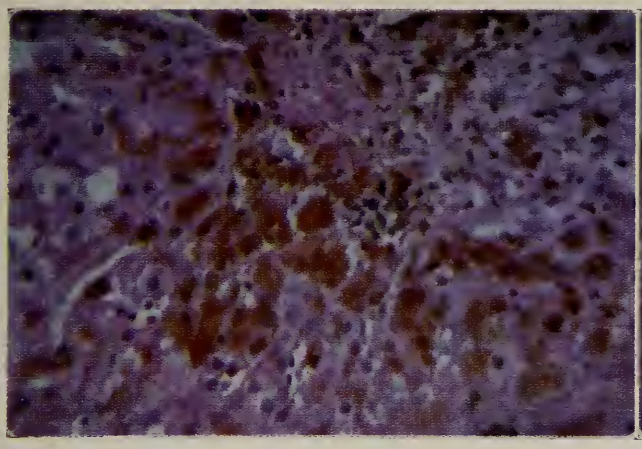


FIGURE 1
HAEMATOXYLIN and Eosin Stain X 150, (1954).

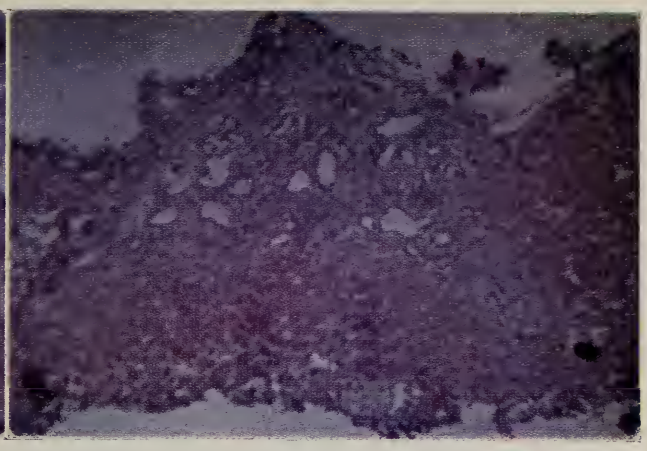


FIGURE 2
HAEMATOXYLIN and Eosin Stain X 35, (1954).

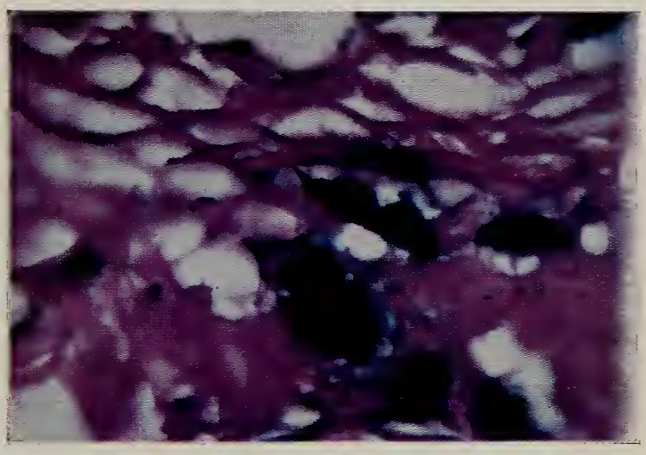


FIGURE 3
GOMORI'S Iron Reaction, (1954).

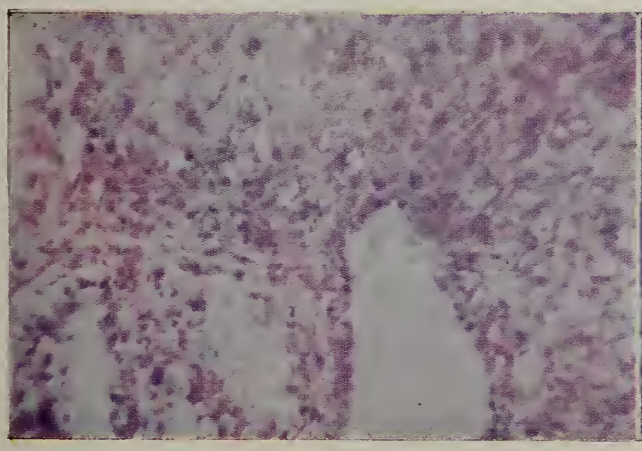


FIGURE 4
HAEMATOXYLIN and Eosin Stain X 150, (1960).

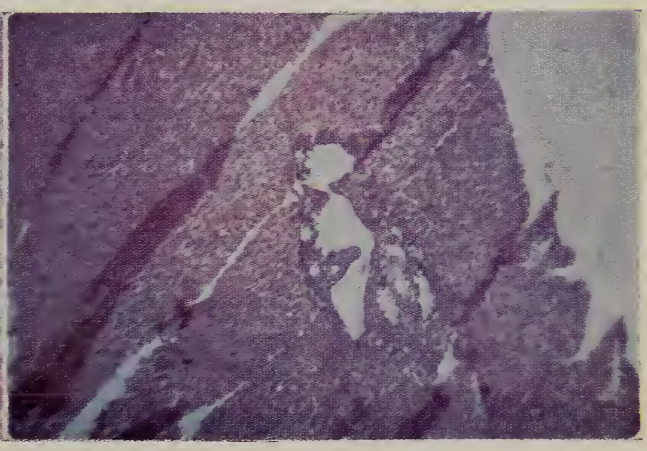


FIGURE 5
HAEMATOXYLIN and Eosin Stain X 35, (1960).

Recently he had had a watery diarrhea of three or four stools per day. He had had no jaundice. He had had frequent nocturia. He had complained of numbness of the third, fourth, and fifth fingers of his right hand. He smoked 20 to 30 cigarettes per day; he drank beer daily, with some whisky at the weekends.

Physical Examination:

The patient was an asthenic, chronically ill appearing 61-year-old white male. The skin was dry and thin and showed a slate gray color over the pressure and exposed areas of the body. There was a marked arcus senilis present. The patient was edentulous. The chest was clear. Heart had a normal sinus rhythm. The blood pressure was 120/80. Pulse rate was 72/m. The liver was palpable three fingers below the costal margin; the edge was round, the surface was smooth and non-tender.

Laboratory Examination:

WBC	7750/mm^3
Hemoglobin	12.9 gms/100 ml
Hematocrit readings	43%
Differential	Normal
Fasting glucose	236 mg/100 ml
BUN	16 mg/100 ml
Serum albumin	4.8 gm/100 ml
Serum globulin	2.5 gm/100 ml

Microscopic examination of a needle biopsy of the liver was made on December 2, 1958. The liver tissue presented the pattern of portal cirrhosis. Evidence of iron storage was present; hemosiderin stains were strongly positive.

During the past three years the patient has felt good. He feels better than he did prior to treatment. He has given up 85 pints of blood since treatment was instituted. He maintains his diabetes on 35 units of NPH insulin. His weight has remained the same. On December 16, 1962, the patient was readmitted to the hospital for re-evaluation of his hemochromatosis.

Laboratory Examination:

Hemoglobin	16.2 gms/100 ml
Hematocrit reading	48%
WBC	10,000
Differential	Normal
Urea nitrogen	20 mg/100 ml
Cholesterol	204
Alkaline phosphatase	3.2 units
BSP	5.5% of dye retained in 30 minutes 1.0% of dye retained in 45 minutes
Acid phosphatase	.40 units
Calcium	9.9 mg/100 ml
Phosphorous	4.2 mg/100 ml
Urine	Normal
SGO transaminase	52 units
SGP transaminase	48 units
Serum iron	312 mg/100 ml
Total iron binding capacity	330 mg/100
Percent of saturation	95
Uric acid	2.5 mg/100 ml
Serum albumin	6.0 gm/100 ml
Serum globulin	1.4 gm/100 ml
Fasting glucose	109 mg/100 ml
Cephalin flocculation	4 + in 48 hours
Bone marrow studies	Normal

Microscopic examination of a needle biopsy of the liver was done December 19, 1962. The sections revealed extensive cirrhosis and dense yellow-brown pigmentation. Hemosiderin stains revealed dense hemosiderin pigmentation.

Discussion:

This patient has been attending a neighboring hospital for his phlebotomies during the past three years. After re-evaluation, it is felt that treatment by phlebotomy had not been intensive enough. Clinically this patient has shown marked improvement, but his liver still reveals cirrhosis and extensive parenchymal iron pigmentation. His skin has improved in the past three years.

Summary

Idiopathic hemochromatosis is described as an iron storage disease. Changes produced in the body depend on the overloading of the body with excess iron which is believed to produce tissue changes. Iron excess may be produced by abnormality in the absorptive mechanism. The triad of hepatomegalia with liver disease, diabetes mellitus, and skin pigmentation is characteristic of iron storage disease. Diagnosis depends upon the demonstration of iron excess in related tissues, most commonly shown by needle aspiration biopsy of the liver. Up to the present time repeated phle-

botomies, with the resultant removal of excess iron from the tissues, have been the only effective therapeutic aid in bringing about an arrest of this disease.

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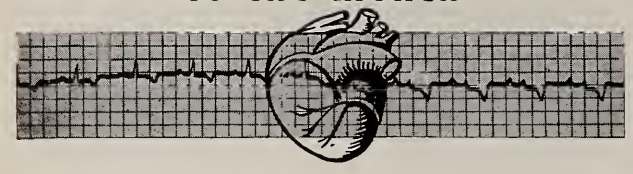
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Insight Spoils "Double Blind" Test

A silly sidelight, but a serious one, is that (FDA) labeling requirements have made some research on patients impossible. The placebo which is used instead of a drug on patients, to make sure that it's the drug and not the patient's attitude that causes changes in his condition, now must be labeled in such a way that he knows when he's getting the medicine and when he's getting the fake. It spoils the experiments.—Editorial in *Journal of the South Carolina Medical Association*, September, 1963.

Electrocardiogram of the month



Presented as a regular feature of The JOURNAL, Electrocardiogram of the Month is a series of short talks on cardiovascular diagnosis and treatment, edited by the staff of the Krannert Heart Research Institute, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis.

Complete Forward Block with Retrograde Conduction

CHARLES FISCH, M.D.
Indianapolis

RETROGRADE CONDUCTION of impulses from the ventricles to the auricle in the presence of complete forward block is a phenomenon rarely observed. Two major theories have been proposed to explain retrograde stimulation of the auricles when orthograde conduction is impossible. These theories are: (1) The mechanical stimulus of the contracting ventricles causes the auricular beats (2) The auricular beats are due to retrograde conduction of impulse from ventricle to auricle through the fibers of the conducting system.

The following case is presented because of the relative paucity of such reports and because it may throw some light on the physiology of impulse conduction in the heart.

An 81-year-old white female was brought to the hospital on 8-18-56, after fainting on the street. Meager history obtained from the family revealed that the patient had been in good health in the past, except for slight exertional dyspnea.

Examination on admission revealed a drowsy elderly female, with blood pressure of 170/95 and pulse of 48. There were moist rales in both lung bases but no other signs suggestive of heart failure. No cardiomegaly was detected. The heart rhythm was regular with an apical rate of 48 beats per minute. Cardiac examination revealed diminished intensity of first heart sound at the apex. There were no murmurs.

Complete blood count and urinalysis were normal. Blood sugar was 106 mg % and blood urea nitrogen was 28 mg %. EKG on 8-18-56 (Figure A) showed complete A-V dissociation. No orthograde or retrograde conduction was exhibited. In the EKG on 8-20-56 (Figure B) the A-V dissociation was again seen, but occasional retrograde P waves could be identified. For detailed description of the cardiograms see the legends under each tracing.

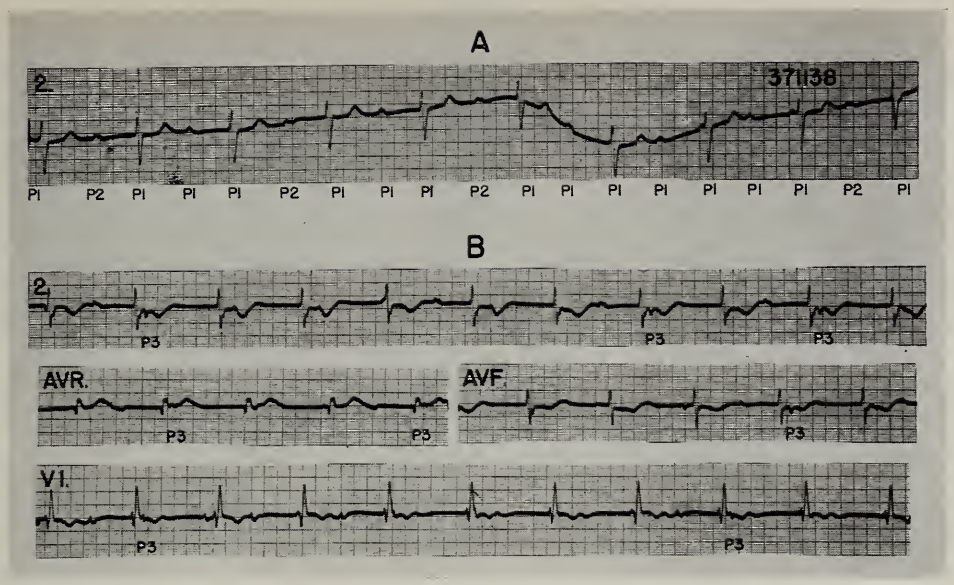


FIGURE A.

THIS STRIP, representing standard limb lead II was taken on 8-18-56 and reveals complete A-V dissociation. The ventricular rate is approximately 40 per minute. Two different P waves are present. One is taller and more peaked (P1). Six consecutive such P waves are seen toward the end of the strip. The atrial rate for these beats is 86/min. The second type of P wave (P2) is smaller and broader. The time interval between P2 and the preceding P1 is longer than the period between two P1's suggesting that P2 may represent an atrial escape beat.

FIGURE B.

THESE STRIPS were taken on 8-20-56. The previously described P waves are again noted. In addition, however, another type of P wave (P3) is seen. This follows the preceding R by a fixed interval of 0.18 sec. This wave is inverted in lead II, AVF, and is upright in AVR. It appears to be diphasic in VI. These waves can be differentiated without any difficulty from the other two types of atrial waves and represent retrograde stimulation initiated by the preceding ventricular impulse.

X-RAY CONFERENCE

Presented as a regular feature of *The Journal*, X-ray Conference is a series of short talks on procedure and radiologic diagnosis, edited by Erich K. Lang, M.D.

Selective Bronchography

ERICH K. LANG, M.D.*

Indianapolis

THIS 52-YEAR-OLD white male was admitted with a history of recurrent hemoptysis over the past months. Several chest roentgenograms had been obtained and failed to show any abnormality. The admission film at Vanderbilt University Hospital, however, did show evidence of atelectasis of the right middle lobe. Bronchoscopy revealed blood coming from the orifice of the right middle lobe bronchus. A lesion could not be visualized. A selective bronchogram demonstrated a cupped filling defect in the medial and lateral segmental bronchus of the right middle lobe. Splaying of the dye column suggested an endobronchial carcinoma with resulting displacement and splaying of the bronchial lumen. All other segmental bronchi and main bronchi were well-demonstrated and appeared to be unremarkable.

Selective bronchography has become an all-important tool in the armementarium for examinations of the lungs. Adequate local anesthesia is readily achieved by spraying the larynx and pharynx with one percent Xylocaine (lidocaine). A nebulizer is subsequently used to achieve adequate anesthesia of the main bronchi. A selective Perkins catheter is then introduced and advanced under fluoroscopic control into the orifice of the desired bronchus. In selective bronchography, the use of Hytrast has been

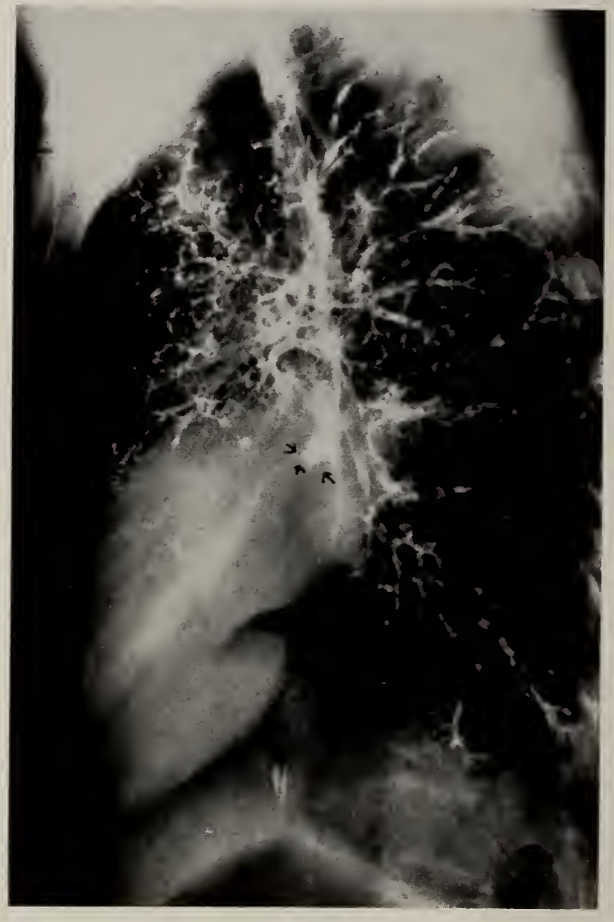


FIGURE 1

NOTE THE ROUNDED filling defect in the lateral and medial segment of the right middle lobe with splaying of the walls of the segmental bronchi. A classical endobronchial lesion is demonstrated. Pathologically the lesion proved to be an endobronchial carcinoma.

*Radiologist, Methodist Hospital and Assistant Professor, Vanderbilt University, Nashville, Tenn.

found to be of great value although this substance is prone to give a slight increase in febrile reactions. The great tenacity of Hytrast results in its firm adherence to the mucosa and guarantees an excellent demonstration of endobronchial lesions such as endobronchial adenomas, carcinomas or inflammatory strictures. This medium tends to give good results particularly in selective bronchography where high detail is desirable to visualize already known lesions.

The selective engagement of each main bronchus and separate demonstration of each segment guarantee accurate detail diagnoses since the overlapping and obscuring by other bronchi can be avoided in this fashion. Selective catheters with a specific curve of their tip will facilitate engagement of a segmental bronchus.

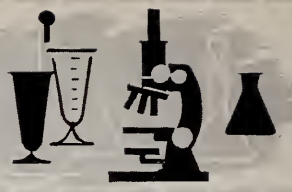
Doubt and Disbelief in Clinical Progress

Not infrequently, it takes years and sometimes decades of widespread clinical experience to evaluate the relative merit of a drug in given conditions. From such long experience, a medical consensus generally emerges but even then some qualified physicians refuse to go along with their colleagues.

History teaches that authoritarian bodies often have been guardians of orthodoxy rather than champions of progress. Medical experts rejected Jenner's smallpox vaccine, Pasteur's anthrax vaccine, Lister's theory of antisepsis and Semmelweis' discovery of the cause of childbed fever. Cod liver oil was rejected as worthless by the Council on Pharmacy and Chemistry of the American Medical Association.

When Prontosil, the first sulfa drug, was introduced in the United States, it was greeted as another quack remedy by an outstanding American authority on infectious diseases. In the early 1930's, the same authority dismissed early English reports on penicillin as incredible and refused to employ for clinical testing a culture of penicillium that had been brought to him by one of his associates. He poured it down the sink.—Theodore G. Klumpp, M.D., at Conference of Professional and Scientific Societies, Chicago, Ill., June 28, 1963.

Path-finder
PUBLISHED UNDER THE AUSPICES OF THE INDIANA ASSOCIATION OF PATHOLOGISTS



Certified Laboratory Assistants (C.L.A.)

JOHN L. ARBOGAST, M.D.
*Indianapolis**

DO YOU NEED a laboratory assistant in your office or clinic group? Recently the "Certified Laboratory Assistant" training program was announced by the American Society of Clinical Pathologists and the American Society of Medical Technologists, who jointly sponsored the new board of "Certified Laboratory Assistants." At the direction of the parent organizations, this board developed essentials in the guidebooks for the conduct of approved schools of laboratory assistants. Currently, applications are being received from a number of pathologist supervised approved schools and hospitals in laboratories throughout the country. Other hospitals are applying for approval for this type of training.

The program is designed to provide accredited high school graduates with one year of practical technical training in routine laboratory work at a level less advanced than that necessary for the professional medical technologist MT(ASCP). The "Certified Laboratory Assistant" will receive national recognition and certification by examination under the auspices of the medical profession, and will receive standardized training and experience. It is anticipated that this category of laboratory worker will be recognized and approved by the American Medical Association House of Delegates in the near future. Hospital administrators have been notified of this program.

Pathologists were instrumental in its establishment. Assistants of one variety or another have been trained locally in certain areas by pathologists and technologists for years. Three relatively recent developments contributed to the national recognition of this new standardized program:

1. The increased expansion of hospital and laboratory facilities and the ever-increasing demand for routine and complex diagnostic laboratory work have taxed presently available personnel beyond the limit.

2. Growth in the complexity of many areas of laboratory work together with automation and routinization has required re-evaluation and re-assignment of primary duties of well qualified laboratory technicians. The professional medical technologist is still in relatively short supply in spite of recruitment. These workers are needed today not only for performing existing functions and procedures but also for the supervision of new, complex, technical laboratory procedures. Competition is so keen in industry for these highly skilled, intelligent individuals that there does not now seem an early likelihood of sufficient numbers being available. There is, therefore, an urgent need for properly trained personnel to perform simpler laboratory tests under the direction of these professionally trained medical technologists, thereby relieving them of considerable routine work.

*Director, Clinical Laboratory, I.U. Medical Center.

3. The great need for additional personnel has resulted in the establishment of some facilities claiming qualifications to train personnel. Those who have been trained, usually within a year at considerably great expense to themselves, have been found insufficiently trained as laboratory workers to substitute for professional medical technologists, and sometimes as laboratory workers in the needed category of assistants. There is no "short cut" for the college degree program type of medical technologist training.

It is believed that the hospital administrator, the pathologist and the supervising medical technologist all realize the need for the establishment of this program. Pathologists and medical technologists have undertaken the establishment of a junior type of training and the establishment of a duly qualified board to examine and to certify such personnel.

As in the past, the primary and pivotal laboratory worker is the registered medical technologist, (ASCP) working under the direction of the clinical pathologist or other qualified physician. The newly recognized category of laboratory worker, the certified laboratory assistant, works primarily under the direction of the medical technologist. Sponsoring societies believe that this relationship must be maintained in the best interests of patient care. To that end, they have joined in the national recognition of a second level of laboratory worker. Since the length of the training program takes a minimum of one year, it will be 1964 before the first of these laboratory workers are available.

Good Riddance to "The Good Old Days"

Anybody who wishes for the return of "the good old days" so as to get things cheaper will realize that the price he has to pay is too great. This was the age of rickets and deformities. Maternal mortality was high. Each infant born had to struggle just to survive. Each adult was lucky if he could live to the age of forty.

The great scourges were tuberculosis, pneumonia, typhoid fever, diphtheria, measles, scarlet fever, smallpox, mastoid and brain abscess, meningitis and many other infections too numerous to mention, but all conquered now. Want to go back to "the good old days"? Would you want the penny prescription of yesteryear for the dollar ones of today, or the life of a century ago for the luxuries of today? Would you trade modern wonder drugs for old-fashioned, home-spun medicaments?

People should know that particularly in health matters, as elsewhere "cheap is cheap."—"An Rx for a Dime" in New York State *General Practice News,* November-December, 1963.

The Journal
of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

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The Framingham Study

"A CONTINUING STUDY of death from coronary heart disease among people with no previous history of heart disease promises to help doctors learn how to predict, and possibly to prevent, such disease in the future."

Dr. Thomas A. Dawber outlined a community study of heart disease being conducted at Framingham, Massachusetts, before members of the Association of Life Insurance Medical Directors at their recent annual meeting in New York City.

The National Heart Institute established the Field Study at Framingham in 1950 to "facilitate the search of knowledge of the epidemiology of coronary heart disease, to determine those host and environmental factors related to coronary heart disease development and to describe those persons most susceptible to the disease."

A total of 5,127 adults, free of any evidence of heart disease, have been observed over a period of years to determine which persons developed coronary heart disease. Subjects have been examined at two year intervals or, when return for examination has been impossible, reports from doctors, hospitals and medical examiners have been collected by mail.

One observation has been that, while the incidence of angina pectoris is not strikingly different in men and women, there is a marked sex difference in the incidence of myocardial infarction and sudden death. Since angina is dependent on coronary narrowing without thrombosis, it is possible that the great disparity between the sexes depends not upon any difference in atherosclerosis, but rather in the proneness to thrombosis.

The original group of patients was classified according to level of serum cholesterol. Early in the study no correlation between elevated cholesterol values and coronary disease was noted. However, after four years it became apparent that the risk of coronary sclerosis was in direct ratio to the cholesterol level.

It was usually observed that the cholesterol determination immediately preceding clinical evidence of coronary change was the only abnormal cholesterol finding. Dr. Dawber thinks that this may suggest that the serum cholesterol level has some immediate effect on the clotting mechanism, and that there is a real benefit obtained

from lowering cholesterol levels.

Experience in the Framingham study strongly supports the previously held view that the blood pressure level is related to mortality and morbidity of coronary disease. "A single casual systolic blood pressure determination has proven to be a good predictor of the subsequent development of coronary heart disease."

Excess weight has been found to be associated with coronary heart disease, most particularly with angina, but has very little effect in relation to infarction. Evidently, patients with coronary sclerosis are more likely to have angina if they have excess weight to carry.

Cigarette smoking is definitely related to manifestations of coronary heart disease. Angina pectoris is not more likely but infarction is significantly increased. This applies to cigarettes, not to cigars and pipes. The effect is not seen in cigarette smokers who have quit.

Dr. Dawber's conclusion is that "The ability to predict this disease serves as a starting point in the development of preventive programs."

Insurance Provides the Financial "Muscle"

THE 18TH ANNUAL REPORT of the Life Insurance Medical Research Fund provides a resumé of past achievements, and a report of future plans.

The fund was organized in 1945 by American life insurance companies, of which there are now 133 contributing to the program of grants in aid and fellowships. Statistical testimony to the stature of the program includes the awarding of $1,295,670 for research in the 1962-63 fiscal year. This brings the total allocations since 1945 to more than sixteen million dollars.

Since its origin, the trustees of the fund have limited their awards to research projects in the fields of circulation and associated diseases of the kidney. This year there are 123 research programs supported all over the United States. One of these, a study of the retinal circulation in man, was started at Indiana University School of Medicine in 1959. Recently funds have been awarded for a two-year extension of this study.

Dr. John B. Hickam, who heads the retinal circulation investigation at I.U., was this year appointed to a five-year term on the Advisory Council of the fund.

Last year a new fellowship was established to aid especially promising undergraduate medical or science students to continue work toward the attainment of a Ph.D. or comparable degree together with the M.D. degree with a view to a career in medical research. There are now 18 such Fellows. One of these, Robert F. Ashman of Indianapolis, has qualified for six years of aid in his studies at Columbia University College of Physicians and Surgeons.

There are 246 fellowships which have been in effect since 1946. Almost all former Fellows are now engaged in teaching and research activities, some full-time and others in connection with active practice. Grants-in-aid have been awarded so effectively that at least some of the advances in every branch of research in cardiac and circulatory diseases have been contributed to by Fellows of the fund.

The life insurance companies of United States and Canada may take pride in furnishing the financial "muscle" for more than 1,000 research projects, and for having aided so successfully the advances of the past fifteen years in the treatment, both medical and surgical, of diseases of the heart and blood vessels.

Guest Editorials

Tetanus Immunization

THAT THE SPORES of Clostridium tetani are so ubiquitous in our environment comes as a surprise to many. Studies made in Baltimore showed spores present in the dust of the streets, homes, offices and hospitals. The idea of the historical "deep

puncture wound from a rusty nail" still persists yet a study of reported cases since 1958 in Indiana reveals the wound providing entrance was often trivial and insignificant in itself.

The hazard of injury from motor vehicle transportation is present daily in most of our lives; motorized garden tools provide another large group of injuries as well. The victims of these "accidents" usually are recognized as being at risk and should receive a booster dose of toxoid or tetanus antitoxin as indicated. The public may regard minor wounds as insignificant and probably will not, unless urged to do so, consult a physician until symptoms of tetanus appear.

During the last 10 years in Indiana, a total of 107 cases of tetanus has been reported and 42 of these cases (39.2%) terminated fatally. Four of these fatal cases were neonatal. Twenty-six cases were six years or younger, 13 cases were 17 to 39 years, 37 cases were 40 years and older, and in two cases the age is unknown. It should be noted that when individual years are studied that fatal termination ranged from 14% to 88.8% of the cases reported for each year.

Tetanus toxoid is highly effective and reactions to it are so rare as to be almost insignificant.* On the other hand the hazard of fatal anaphylactic shock followed by death within an hour has occurred with only a skin test of 0.1 cc. horse serum tetanus —antitoxin in a 1:10 dilution with isotonic sodium chloride solution given intradermally.†

The AMA has launched an educational program to physicians and the public urging wider use of tetanus toxoid. It is hoped the above will be of assistance to you in discussing with your patients the advisability and urgency of protection against tetanus and necessity of booster injections every four to five years and/or at the time of injury.—Reprinted from the *Technical Bulletin* of the Indiana State Board of Health, No. 4, October, 1963.

*Edsal, G.: Specific Prophylaxis Against Tetanus. *JAMA* 171:417-427, 1959.

†Buff, B. H.: Fatal Anaphylactic Shock Following Intradermal Skin Test with Dilute Horse Serum Tetanus Antitoxin. *JAMA* 174:1200-1201, 1960.

Case of the Nameless Pill

. . . Life and death
At 12 Percent

JUST ACROSS THE RIVER from Detroit, there is a Canadian diabetes sufferer today who knows that a penny saved can be hospitalization earned. He learned the hard way to be thankful to be alive. More importantly, his case is joining pharmacists and physicians in a renewed effort to uphold the prescribing rights of health practitioners.

The story began last year when diabetes was diagnosed and tolbutamide was prescribed for the patient. For 11 months the medicine permitted him to go about his daily tasks in reasonable good health. Then suddenly, unexplainably, his disease went out of control. His fasting blood sugar level rose rapidly. He was near collapse. He had to be taken to a hospital. Once there, he climbed back toward recovery. What had happened?

The patient's physician, Arnold K. Carter, M.D., of Windsor, Ontario, in a letter to the *Canadian Medical Association Journal,* tells how medical sleuthing solved this whodunit. His first clues were undissolved tablets recovered from the patient's stools. When the pills were analyzed, along with the remainder of medication, they revealed a proper amount of tolbutamide. That eliminated the possibility of a different chemical being dispensed.

But wait—the drug company which handled the laboratory analysis also reported that this was not its product, al-

though the firm's brand had been on Dr. Carter's original prescription. Whoever made the suspect tablets had not exerted the quality control to assure proper disintegration and solubility. What about that, he asked? Well, yes, the patient admitted, he had later obtained a refill of cheaper, unbranded drug to save what amounted to 12 cents on the dollar. Sadder but wiser, he is back now on the specific medicine.

"In other words," Dr. Carter informs his colleagues, "although the refills contained the labeled quantity of drug, they were to all intents and purposes quite useless. Since diabetes is one of the few areas of therapeutics where failure of response to a drug can be observed clinically and measured objectively, I consider this instance most significant and revealing. It makes one wonder how many product failures occur in other circumstances where results are less obvious or dramatic."

Agreeing is a Montreal pharmacist, L. Gosselin. He writes in the same issue of the medical journal: "Pharmacy and medicine should stand together on this most important issue of the physician's right to prescribe drugs of his own choice—drugs made by a manufacturer whose reputation is beyond reproach and whose products have been submitted to all the tests, and not only to the test of being cheapest in price."

To all this, the *Canadian Medical Association Journal* editor adds his word: "The patient can contribute in a positive way to his own care if he will refrain from applying pressure to employ a cheaper substitute for a brand-name product of established efficacy. It may be a matter of surprise to some that certain physical characteristics, such as the degree of compression applied when manufacturing a tablet (hence, its solubility), are fully as important in achieving the desired therapeutic effect as is the purity or potency of the specific agent.

"The physician may be wiser to give his confidence to those who package their reputations with their products than to those who, remaining nameless, purvey a nameless 'generic' drug."—Reprinted from *Medicine At Work,* May, 1963.

Editorial Notes . . .

Medical education in the United States will soon be 200 years old. The University of Pennsylvania School of Medicine was founded in 1765—until that time, all physicians in the colonies were educated in Europe. The original Pennsylvania faculty members were all graduates of the University of Edinburgh, Scotland. Celebration of the bicentennial will begin in late 1964 when the first of some 45 medical and scientific organizations, national and international, will hold their regular conferences and conventions in Philadelphia.

Most ordinary cloth may be fireproofed with a new flame retardant called APO-THPC. Developed by the Department of Agriculture and the Army Quartermaster Corps, the new chemical may be used for cotton, wool, rayon, silk and blends of these but not for nylon or cellulose acetate. It may be applied to unprocessed cloth or to clothing, bedding or draperies, in a conventional institutional laundry machine. It is irritating to skin but after being fixed to the cloth it is non-irritating and will not wash out with repeated launderings. It affects little or no change in the appearance of the fabric.

"Never had it so good." A gourmet dinner may be ordered for a patient by a friend or ordered by a patient for $3.50, if the patient's diet is not violated, in the Rowan Memorial Hospital at Salisbury, North Carolina. Strip steak, broiled lobster, king crab or frog legs are available and are served with all the trimmings on special china with a tray cover and finger bowl included. Gourmet gift certificates are sold to friends who wish to brighten the day for the convalescent. An added innovation is that the uptown dinner is served at any hour the patient elects.

Expansion of medical education is documented by the recent report of the AMA

Council on Medical Education and Hospitals. Firm commitments have been made for the construction of six new medical schools—making a total of 11 new schools now in the planning stage. Medical school applicants have increased for the first time in six years, this time by 10%. Another shortage is being lessened by enlargement of the supply of medical teachers. The newest of the newly planned schools are the University of Arizona; Mt. Sinai Hospital, New York City; University of Massachusetts, University of California at San Diego; Michigan State University and Pennsylvania State University. These are in addition to five schools previously announced—New Mexico, Rutgers, University of Texas, Brown and University of Connecticut.

The hospital ship, S. S. HOPE, has sailed on its third medical service and medical education voyage. This time it is headed for Ecuador. It has been to Indonesia, South Viet Nam and Peru previously. Eighty-three doctors, nurses and other medical personnel constitute the permanent staff, which will be augmented by rotating teams of about 30 physicians and dentists who serve for two months each. Seven individuals on this voyage have been on previous trips. Just prior to embarkation an invitation was received from the Republic of Guinea, urging that that nation be the object of the next medical voyage.

NAPAN (National Association for the Prevention of Addiction to Narcotics) is planning for six halfway houses to be located in four major American cities—New York, Chicago, Detroit and Los Angeles—cities where most of the addicts live. The function of the halfway houses will be to shelter addicts who have just been released from hospitals for narcotic addiction or from prison. On release the patient needs food, clothing, shelter and a job. A patient, who is broke and down-and-out, will upon release from custody usually gravitate to his previous environment and without help will revert to narcotics usage.

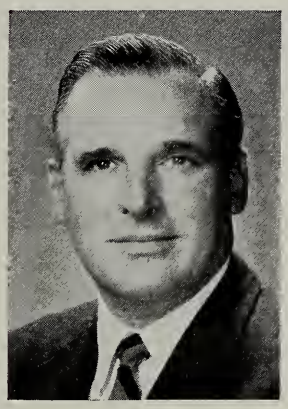
The National Foundation for Asthmatic Children of Tucson, Inc. has been charged with spending 59% of the funds raised for expenses of fund raising. The Better Business Bureau emphasizes that the unordered merchandise which this outfit and many others distributes with request for payment need not be paid for and need not be returned.

The number of people employed in the health care industry was up by 46% from 1950 to 1960. At the same time persons in all occupations increased by only 16%. In 1960, there were 1.9 million individuals working in health care, making it comparable in size to other industries, and ranking close to third in size. Hospital and other institutional employees have increased the most, medical and dental technicians are next highest. As is true with all occupations, the proportion of women workers is increasing—the number of women in health care increased in the decade by 59%, men by 26%.

President's Page

As we begin the new year, it is customary to take a glance backward to see the path which we have travelled—then immediately face forward to the task ahead.

The year 1963 saw many accomplishments to the credit of physicians and medical organizations. Success in activities toward legislation which would improve the health of the people of our state; success in our efforts to stave off attacks of those who would bring socialized medicine as a burden upon the people of this nation and success in developing among all an awareness of the responsibility of the local community in solving many of their health problems. This was accomplished through a series of regional meetings on mental health, health service plan, and through two statewide conferences on problems of the aged.



While our successes in the past are those which would naturally make us feel that the accomplishments were worth the effort, as we look forward to the coming months, the picture is one that might be likened unto a photograph taken on a dark and dismal day. The year 1964 shows evidence of being one of the most critical years facing not only organized medicine but also our patients. There are many strong proponents of socialized medicine who will put forth every effort to bring to a successful conclusion their long battle to provide medical care for all over 65 through the Social Security system. We all realize that this is merely a foot in the door toward a complete system of socialized medicine in this nation.

We are all aware that evidence proves that people over 65 are not destitute and not being denied good medical care because of their inability to pay. Nevertheless, during 1964, we shall see a strong play made to show that such is the case. If the proponents are not successful during the second session of the 88th Congress, you can be assured that it will become a political issue during the election in the fall. Therefore, every doctor, his wife, his family and all the friends he can enlist, must now begin to work shoulder to shoulder to defeat one of the greatest steps that would be made toward a socialized system if this type of legislation is enacted in this nation.

We must be alert to every political maneuver and to the points at issue. We must be fully cognizant of what the candidates for Congress in 1964 believe. We must make sure they are high-principled individuals whose first thought is the preservation of this Republic. We must dig deep into our pockets to help those who *are* so principled to carry on effective campaigns which would insure their election.

You will, therefore, be called upon to make many sacrifices during the coming months. You will be called upon to support I-HOPE and AMPAC. You will be requested to actively participate in an educational program at your community level. Only with your support can we do our share in maintaining the rich heritage which has been left to us by those who have gone before.

The Woman's Auxiliary

REPORTS TO ISMA

In evaluating the progress of our achievements, I find that legislation is the priority project of most of the auxiliaries. This is manifested by the aid extended to the medical societies in organizing "Operation Hometown." For example, Randolph County has formed a "Doctors' Study Group" which meets once a month. Several physicians and their wives organized this non-partisan educational club to study current legislation, organize public meetings, and provide speakers for service clubs and other groups, large or small.



The interest and accomplishments in International Health Activities (I.H.A.) are impressive. Our I.H.A. chairman, Mrs. W. Burleigh Matthew, has told the story of the need for medical and para-medical supplies among the world's underprivileged to many of the auxiliary groups. Sue's dedication to this work of helping the less fortunate has given us the incentive and opportunity to help and serve with our hearts.

Under the leadership of Mrs. Richard Horswell, Mental Health Chairman and with the attendance of many of our county officers at the Mental Health Regional Meetings, more of our members are recognizing our obligation and responsibility in helping with the mental health program. Some of the members are doing volunteer work with mental patients and the retarded. Many of the auxiliaries contributed money or gave Christmas gifts to patients in the mental hospitals.

The sale of Christmas cards, with the auxiliary receiving 40% of the sale price, has proven a painless way of contributing to AMA-ERF. No figures are available at this time, but with more auxiliaries participating in the project, we are anticipating good results. Several of the groups have had or are planning to promote fund raising parties and projects. We are stressing the importance of contributions to the AMA Guarantee Loan Fund.

The interest in the Health Careers Program under the guidance of Mrs. Harold R. Griffith, Health Careers chairman, brings into focus the necessity of continuing to assume the task of encouraging and directing personnel into the health fields.

All our projects are important but I have mentioned only these few to show that our members truly believe, "I am My Brother's Keeper."

Zelda K. Sullivan

who were the "untreatables"?

From their inception with cortisone, to the present-day variants of the steroid molecule, the corticosteroids have presented a therapeutic paradox. The beneficial action against inflammation and allergy as well as several undesirable metabolic effects are all, apparently, the results of the same basic physiologic action.[1]

Some of these associated metabolic reactions made it risky or otherwise undesirable to treat with steroids large numbers of patients in various categories who would otherwise have benefited from such management. These "untreatables" were overweight, had cardiac disease, hypertension, or pulmonary fibrosis associated with congestive heart failure. Also in this category were those patients whose emotional symptoms were aggravated by earlier steroids.

But the advent of ARISTOCORT® Triamcinolone in 1958—the result of biochemical and pharmacologic research which successfully stripped away many important undesirable hormonal effects from the primary anti-inflammatory action—dramatically changed this picture. This steroid did not overstimulate the appetite, or cause the excessive weight gain induced by other steroids;[2-7] it proved to have one of the best records of any steroid for *not* causing edema, or salt-and-water retention;[2,3,7-10] and the incidence of undesirable euphoria with this agent was remarkably low.[2,4,5,9,10] What is most significant is that these benefits have stood the test of more than 5 years of widespread use. And, of course, the avoidance of these distressing hormonal effects benefited *all* patients requiring steroids, not just those in the special categories, as demonstrated by wide clinical use.

Side Effects. Since it may, under some circumstances, produce any of the unwanted effects common to all cortisone-like drugs, discrimination should always be exercised in administering ARISTOCORT® Triamcinolone. Any of the Cushingoid effects are possible, as are purpura, G.I. ulceration, increased intracranial pressure and subcapsular cataract. Corticosteroids generally may mask outward signs of bacterial or viral infections. Catabolic effects to watch for include muscle weakness and osteoporosis. Weight loss may occur early in treatment but is usually self-limiting.

Contraindications. While the only absolute contraindications are tuberculosis and herpes simplex, there are some relative contraindications (peptic ulcer, glomerulonephritis, myasthenia gravis, osteoporosis, fresh intestinal anastomoses, diverticulitis, thrombophlebitis, psychic disturbance, pregnancy, infection) to weigh against expected benefits.

While no steroid can *cure* a susceptible disorder, many patients who would otherwise be confined in a state of invalidism have, on ARISTOCORT® Triamcinolone, been able to pursue active, useful lives.

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Report on Actions of the House of Delegates American Medical Association

17th Clinical Meeting
December 1-4, 1963
Portland, Oregon

PORTLAND, Dec. 4—Four resolutions presented by the Indiana State Medical Association were among the major subjects acted upon by the House of Delegates at the American Medical Association's 17th clinical meeting December 1-4 in Portland.

Three of the resolutions were passed; the fourth was not although the AMA took positive action upon its recommendations.

Passed were the following resolutions:

1. Recognition of Lieutenant Elmer Paul, former sergeant with the Indiana State Police, for his origination of the Auto Crash Injury Research program.

2. Request the repeal of the Kefauver-Harris Amendment on the efficacy of drugs.

3. A study be made by the AMA and the United States Public Health Service and the industry in providing a type of detergent that will assure safety to the health of the public.

Although the Indiana resolution on setting up an accrediting agency for Voluntary Health Agencies was not passed, the AMA did agree to hold a national meeting in the spring of 1964 with representatives of all Voluntary Health Agencies, industry and labor to review the activities of Voluntary Health Agencies and for the purpose of establishing a code of mutual understanding and cooperation.

In other action, the house also agreed with a recommendation that the Committee on Voluntary Health Agencies be given the status of a council in the AMA organizational structure. Dr. Norman Booher, chairman of the ISMA Commission on Voluntary Health Agencies, was named a member of the council.

Indiana's delegation to the meeting was composed of Drs. Harold C. Ochsner, Indianapolis; E. S. Jones, Hammond; Francis L. Land, Fort Wayne; Guy A. Owsley, Hartford City; Jack E. Shields, Brownstown, delegates; and Drs. Robert M. Brown, Marion; Frank H. Green, Rushville; William B. Challman, Mt. Vernon; John M. Paris, New Albany, alternates.

Also attending from Indiana were all the members of the ISMA Executive Committee. Dr. Ochsner served as a member of the AMA Reference Committee on Medical Education and Hospitals and Dr. Jones served as a member of the AMA Reference Committee on Public Health and Occupational Health.

Members of the association met at breakfast with the delegates and alternates to discuss resolutions and other matters coming before the house. Decisions were then made as to the position Indiana delegates would take on various proposals.

The delegates and alternates were split up so that all reference committees were covered by a representative of the association. This way the delegation had first hand knowledge of the discussions which came before the reference committees.

House Actions

Tobacco and health, the rights and privileges of Negro physicians, revision of the AMA Constitution and Bylaws, voluntary health agencies and blood banks were among the major subjects acted upon by the house.

The AMA Layman's Citation for Distinguished Service was awarded for the sixth time, and for the first time at a clinical meeting, to Mr. M. Lowell Edwards of Santa Ana, Calif., and Brightwood, Oregon. Mr. Edwards, a 65-year-old retired engineer, has designed and built artificial heart valves now in use in more than 2,600 persons with diseased hearts.

The house at its opening session expressed deep shock at the tragic death of the late President John F. Kennedy and directed that a letter of heartfelt sympathy be sent to Mrs. Kennedy, her children and

the late President's family. The house also pledged its support to President Lyndon B. Johnson in forging national unity in the weeks and months ahead and offered the association's resources, counsel and cooperation on matters of health.

Dr. Edward R. Annis, AMA president, reporting on the recent House Ways and Means Committee hearings on the King-Anderson Bill, told the house:

"The combined testimony of the American Medical Association, the state societies and our allies made a far greater impact on the members of the committee, friend and foe alike, than at any other time in the history of this long and bitter conflict."

Dr. Annis also reported that under questioning from Committee Chairman Wilbur Mills, actuaries of the Department of Health, Education and Welfare admitted that the program of tax-paid hospitalization and related benefits for the aged proposed in the King-Anderson Bill would require a tax rate twice as high as they have previously claimed.

Final registration at the Portland meeting reached a total of 7,103, including 3,144 physicians.

Tobacco and Health

The house approved a board of trustees proposal that the American Medical Association Education and Research Foundation undertake a "comprehensive program of research on tobacco and health."

Agreeing that many gaps exist in knowledge about the relationship between smoking and health, the house declared that the study should be "devoted primarily to determining which significant human ailments may be caused or aggravated by smoking, how they may be caused, the particular element or elements in smoke that may be the causal or aggravating agent, and methods for the elimination of such agent."

The action called for procuring a project director "whose experience, qualifications and integrity will assure that such a research project will be conducted effectively, exhaustively and with complete objectivity."

The house agreed that the project should be financed by a substantial contribution from the American Medical Association and that contributions should be solicited from other sources—industry, foundations, voluntary health agencies and physicians. It was emphasized that contributions will be accepted only if they are given without restrictions.

Subsequent to the house action, the AMA Board of Trustees voted to contribute $500,000 to help finance the research program.

Negro Physicians

The house considered two proposals related to Negro physicians—a board report on hospital staff privileges and a resolution concerning membership eligibility in state and county medical societies. The board report was approved, but the resolution was not adopted.

In adopting the board report, the house declared that "members of the medical staff of every hospital, where the admission of physicians to hospital staff privileges is subject to restrictive policies and practices based on race, be urged to study this question in the light of prevailing conditions with a view to taking such steps as they may elect to the end that all men and women professionally and ethically qualified shall be eligible for admission to hospital staff privileges on an equal basis, regardless of race."

In both its approval of the board report and its rejection of the proposed resolution —which would have denied the rights and privileges of AMA membership to members of any state or county society which refuses membership to any qualified physician because of race, religion or place of national origin—the house reaffirmed 1950 and 1952 policy actions on this subject and directed that a copy of the 1950 resolution again be sent to each state and county medical society. That resolution urged that "constituent and component societies having restrictive membership provisions based on race study this question in the light of prevailing conditions with a view to taking such steps as they may elect to eliminate such restrictive provisions."

AMA Constitution and Bylaws

The house approved comprehensive revisions and rearrangements of the association's constitution and bylaws as submitted by the Council on Constitution and Bylaws.

Among the changes are the following:

1. The annual and clinical "sessions" have been renamed the annual and clinical "conventions."

2. The word "constituent" has been changed to "state."

3. Two types of membership have been created, "active" and "special." Active members are regular or service members. Special members are associate, affiliate and honorary members.

4. Affiliate membership will be available to American physicians engaged in medical missionary and similar educational and philanthropic labors located in possessions of the United States.

5. A quorum will be 100 of the voting members of the house rather than 75.

6. A method has been established to replace a general officer who misses six consecutive meetings of the board of trustees.

7. A method has been established for the successor to the president to assume the office of president if the president dies, resigns or is removed from office.

8. The board of trustees has been given express authority to appoint committees.

The house retained present provisions concerning voting on amendments to the constitution but agreed that this matter might be considered by the Committee to Review the Organization of the AMA House of Delegates.

Voluntary Health Agencies

In approving a board report on professional relationships with voluntary health agencies, the house declared that "the AMA maintain its policy of neither approving nor disapproving national voluntary health agencies." It also agreed "that the AMA, through its Committee on Voluntary Health Agencies, maintain its position of offering guidance on medical aspects of national voluntary health agency programs."

The house approved the "Principles for Medical Guidance to National Voluntary Health Agencies" which contain a new definition of a voluntary health agency, objectives of the Committee on Voluntary Health Agencies and a list of suggested mutual obligations between the AMA and the national voluntary health agencies. The house directed attention to the following two obligations:

"There should be a mutual exchange of information and opinion enabling the medical profession and the agency to understand each other's policy and practice."

"A national voluntary health agency should seek the advice of the medical profession when embarking on a national medical program."

Blood Banks

The house adopted a policy statement pointing out that in recent years there has been a dramatic growth of blood banking facilities in the United States and declaring that "it is highly essential that the organization of new blood banking programs and the modification of existing ones should have, in the interest of public health and safety, the approval of the county or district medical society and, therefore, should be coordinated with existing approved blood banking facilities." The house also approved a floor amendment stating that since a blood bank can well be considered a medical facility, the top authority in a blood bank should be a physician.

Miscellaneous Actions

In considering a wide variety of reports and resolutions, the house also:

Changed the name of the Council on Scientific Assembly to the *Council on Postgraduate Programs;*

Extended AMA affiliate membership to *scientists* in sciences allied to medicine;

Changed the name of the Council on Medical Education and Hospitals to the *Council on Medical Education;*

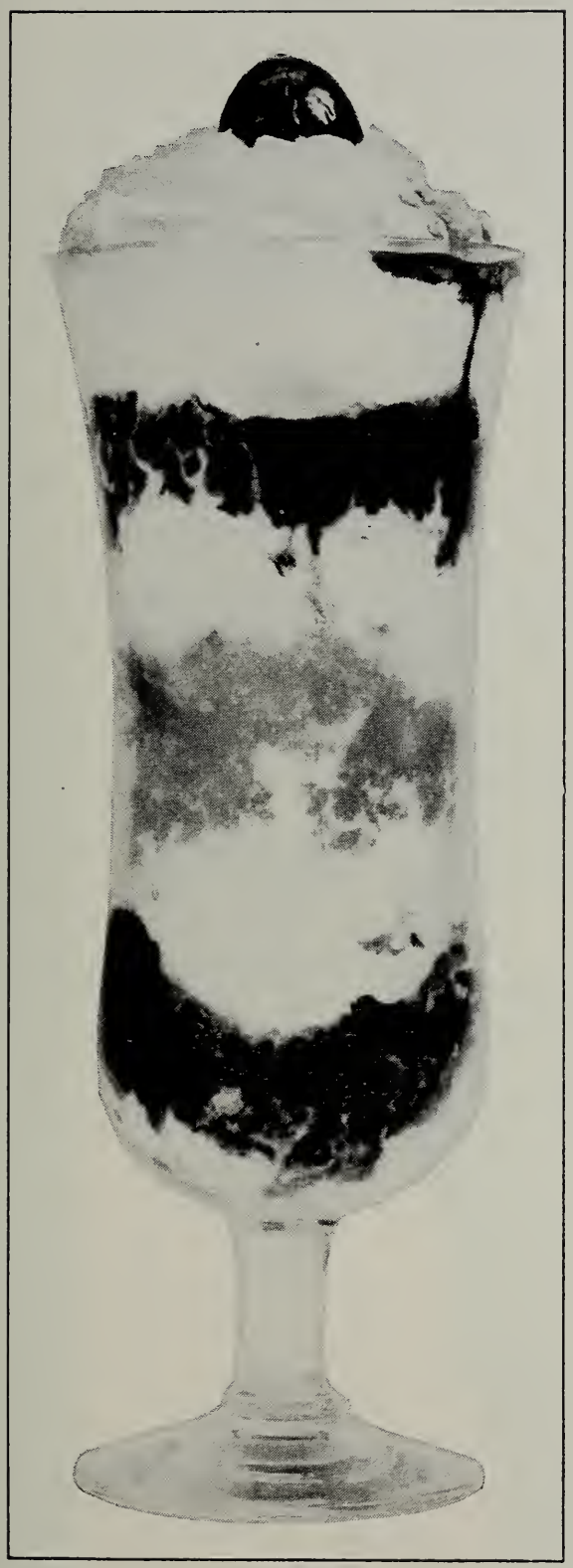
Approved an amendment to the Bylaws which would permit the *opening session* of the House of Delegates to be held on Sunday afternoon or evening;

Expressed gratification that the work of the *Committee on Medicine and Religion* has received widespread acceptance and support from state and county medical societies, religious groups and other related organizations;

Received a report on the AMA members *retirement plan* and urged physicians to act quickly if they are to exercise their rights under Public Law 87-792 during 1963;

Requested the AMA to seek improve-

Continued



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ments in the format of its *American Medical Directory* to make it easier to use;

Asked the association staff to study the feasibility of opening the *clinical meeting* two Sundays prior to Thanksgiving Day;

Approved recommendations for criteria on medical examinations for *driver limitation* under certain specified conditions;

Urged that the term *"the aging"* be used instead of "the aged" in all statements by the medical profession regarding older persons;

Approved the *"Guides for Medical Society Committees on Aging"* and recommended their wide distribution and use;

Received a progress report from the *Commission on the Cost of Medical Care,* which will present its final report in June, 1964;

Agreed that the *Committee on Rehabilitation* should be reconstituted and that it should include participation of knowledgeable representatives of all related fields of the practice of medicine;

Earnestly recommended that the state medical societies explore the advantages of implementing *Kerr-Mills programs* in a manner which will permit the care of beneficiaries under voluntary health insurance programs;

Reaffirmed the association's policy of opposing the inclusion of self-employed physicians under *Social Security;*

Agreed that a *short form medical record* may be used in cases of a minor nature and, in general, should apply to hospital stays of 48 hours or less;

Approved a board of trustees conclusion that the *Honors and Scholarship Program,* originally proposed in 1960, not be implemented in the light of present circumstances, and

Urged all AMA members to continue to support the *Woman's Auxiliary* so that it can be successful in increasing its membership, raising more revenue and broadening its range of activities.

Contributions and Tributes

Merck Sharp and Dohme pharmaceutical company made its third contribution of $100,000 to the student loan fund of the American Medical Association Education and Research Foundation. The AMA-ERF also received a total of almost $400,000 from physicians in three states for financial aid to medical schools.

The house paid tribute to Mr. Thomas A. Hendricks, who is retiring on December 31, for his 20 years of AMA service. Dr. Annis was "commended and encouraged in his great work for private enterprise and free American medicine." By a rising vote of acclamation, the house also expressed appreciation to Dr. Jesse D. Hamer of Phoenix, Arizona, who is retiring after 30 years as a delegate.

F. J. L. Blasingame, M.D.
Executive Vice President
American Medical Association

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Medicine At Law

DECISIONS AND OPINIONS

Highlights of recent court actions pertaining to health and medicine from *The Citation* prepared by the Law Division of AMA.

Radiologist and Hospital Found Negligent in Patient's Fall During X-ray Exam—Insurers of a radiologist and the hospital in which he practiced were held liable for injuries sustained by a 71-year-old woman who fainted and fell while X-rays were being taken. The radiologist was negligent in not taking the patient's medical history before starting the X-rays, an intermediate appellate court in Louisiana held, even though it was not customary for radiologists in the locality to do so. The medical history would have disclosed that one of the purposes of the X-ray examinations was to determine the cause of the patient's fainting spells. The nurse and the technician who assisted with the X-rays, both hospital employees, were likewise found negligent in failing to take the medical history.

The patient was admitted to the hospital by her regular physician for a general checkup, after she had complained of stomach pains, fatigue, and fainting. On the day after she was admitted, she was taken to the radiology department for chest, gallbladder, and gastrointestinal X-rays. The department was operated by the radiologist under a contract with the hospital which provided for a division of the net proceeds. During the course of the examinations the patient, while standing on the footboard of the X-ray table, suddenly fainted and fell. Neither the radiologist nor the technician saw her fall. She sued for damages for injuries sustained, which required surgery, and for complications requiring additional surgery.

There was expert testimony that it was not the custom in private hospitals in the locality for the attending physician to furnish the radiologist with a patient's medical history. However, in hospitals which serve as teaching institutions, it is a requirement that a patient's clinical history be placed on a request for an X-ray examination. Since such a precaution is considered necessary to guard against injury to a patient from a reasonably foreseeable contingency, the court said, it is no defense to a malpractice suit that the precaution is not customarily taken by doctors in the locality. To hold otherwise would be to exempt a doctor from even willful negligence on the unsound ground that others in the profession do likewise. Regardless of the custom in the locality, the court concluded, a doctor is under a duty to exercise reasonable care and skill, together with his best judgment.

The possibility of any patient fainting during an X-ray examination is one which radiologists and technicians are trained to watch for and guard against. In this case, taking of the patient's medical history would undoubtedly have prompted increased alertness on the part of both the radiologist and the technician, the court said. Not only were both negligent in failing to obtain the patient's history, but similar negligence was also shown by the floor nurse in failing to enter the history on the patient's X-ray requisition card.

Favalora v. Aetna Casualty & Surety Co., 144 So. 2d 544 (La., June 29, 1962).

Failure to Make X-ray may be Basis for Liability—Although the failure of a physician to make an X-ray is not proof of negligence in every case, it may constitute such proof under circumstances which indicate that a fracture is a probability. In such circumstances, expert medical testimony is not

required to support a finding of negligence on the part of the physician, the Pennsylvania Supreme Court ruled.

A 70-year-old patient slipped and fell in his home. He suffered severe and constant pain in the area of the knee and hip of his right leg. On manipulation of the leg a "crunching" noise was noted in the hip area. No X-ray was made until 11 days after the fall, when the patient was hospitalized.

The appellate court reversed a nonsuit, which was granted because of the absence of any expert medical testimony to establish negligence on the part of the physician it said:

> "The circumstances here command an exception to the general rule which requires the production of expert testimony for it is a matter of common knowledge that the fall of an elderly person may be due to or accompanied by a fracture of the bony structure of the body; furthermore, when subsequent to such fall, the patient suffers severe pain, a "crunching" noise in the hip where the severe pain is centered, an outward turning of the leg and other symptoms, such symptoms point to the necessity for the use, in arriving at a diagnosis, of the commonly accepted method of fracture detection, i.e. the X-ray. Resolution of the issue whether, under the instant circumstances, this physician should have resorted to the use of X-rays as an aid in arriving at his diagnosis, requires no expert testimony; it is within the ken of every layman. It can be presumed that a jury has some knowledge in areas such as this even though doctors have superior knowledge. In this day and age, the average member of a jury has a general knowledge of the efficiency of X-rays as an aid to diagnosis together with the ability to evaluate whether the failure of the physician to take X-rays, under the presented facts, evidenced a lack of judgment and



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care in arriving at a diagnosis on the part of the physician."

One judge dissented from this decision, particularly with respect to the last sentence quoted above.

After the patient was hospitalized, an orthopedic surgeon attempted to fix the fracture. After two unsuccessful attempts with a Smith-Peterson nail, he used a Steinman pin. The patient also sued the orthopedic surgeon, claiming that the insertion of the Steinman pin was without his consent. Although he had signed a general consent, the patient claimed that the consent was later orally limited to manipulation of the prosthesis and did not extend to insertion of the Steinman pin. A nonsuit on this claim was affirmed on appeal. The court said that the insertion of the pin was part of the authorized relocation of the dislocated hip fracture, in the absence of any evidence to the contrary.

Smith v. Yoke, 194 A.2d 167 (Pa., Oct. 9, 1963).

Hospital Liable for Patient-to-Patient Staph Infection—A judgment awarding damages of $67,839.97 to a patient in a suit against a hospital for injuries resulting from a staphylococcus infection contracted while in the hospital was sustained by the Washington Supreme Court. The evidence was sufficient, the court ruled, to present jury questions as to whether the patient acquired the infection through a cross-infection from his roommate and as to whether such cross-infection was due to negligence by the hospital in the care of the patient and his roommate. The award included compensation for anticipated future medical expenses, as well as consequential damages to the patient's wife.

The patient, injured in an automobile accident, was transferred to the hospital from another hospital, for hip surgery. He was placed in a two-bed ward, the other bed being occupied by a patient admitted to the hospital with a fractured back. Following surgery, the patient was returned to the same room.

Eight days after the patient's surgery, his roommate complained of a boil, and the following day purulent drainage from the boil appeared. A culture from the drainage was submitted to the hospital laboratory, and three days later the laboratory reported that the drainage was staphylococcus aureous coagulase positive. The roommate was then removed to an isolation ward.

In the few days elapsing between the time the drainage appeared and the time the roommate was removed to the isolation ward, nurses and hospital attendants administered regularly to both patients. They moved from one patient to the other, carrying out routine duties, giving sponge baths, changing sheets, administering back rubs, changing dressings, and the like. They did not wash their hands between administering to the two patients or observe the sterile technics prescribed by the hospital in cases where infection is suspected.

On the day the roommate was placed in isolation, the patient's surgical wound erupted, causing purulent drainage. A culture of the drainage showed it to have been caused by staphylococcus aureous coagulase positive.

Since a cross-infection between patients would be a medical impossibility unless they

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were both infected with the same strain of staphylococcus aureous coagulase positive, proof of infection with the same strain was essential. Identification of the strain was made by employing two tests: the antibiogram sensitivity test and the phage test. However, expert testimony was in conflict as to the accuracy of the results obtained by the two types of tests. A hypothetical question put to an expert testifying as to the efficacy of the tests was upheld by the high court as meeting the requirements that it be based upon the facts in the record and that it fairly and comprehensively cover the facts upon which the answer was to be based.

The court ruled that there were strong circumstances from which the jury could find that the cross-infection occurred. Among those circumstances were the time element of the infections, the fact that nurses and attendants administered to both patients without observing sterile precautions, and the fact that massive transfers of bacteria can be accomplished by coming into contact with infected areas and then touching other persons. Thus, the jury's determination was not based upon an unsupported inference.

The allowance for such future medical expenses as might be anticipated was held proper, in view of the patient's physical condition. The infection had required a second operation, in which the patient's hip was fused in a nearly immovable position.

Helman v. Sacred Heart Hospital, 381 P. 2d 605 (Wash., May 10, 1963).

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Otis J. Burwell, Quarters 12C Maxwell AFB, Montgomery, Ala.

SPECIALISTS

A. Bashir Elahi, Veterans Administration Hospital, Louisville 2, Ky.—*Internal Medicine*

Russell F. Mading, 7267 Renda St., Millington, Tenn.—*Ob-Gyn—Group or Associate*

Richard P. Rudnicki, 276 Englewood St., Apt. 5B, Englewood, N. J.—*Ob-Gyn.*

William T. Harris, 5652 Bixby St., Pershing Park, Killeen, Tex.—*Ob-Gyn.*

Gene M. Kuehn, 316 Magruder, Wolter Village, Mineral Wells, Tex.—*Ob-Gyn.*

Mariano Tan, % St. Boniface General Hospital, St. Boniface, Manitoba, Canada—*Pediatrics*

Leland L. Wince, 3640 Cushing Drive, Apt. C, Columbus 27, Ohio—*Pediatrics*

Thomas P. Leonard, 1929 3rd Ave., N. E., Rochester, Minn.—*General Surgery*

Harry J. Weber, 823 Thomasville Rd., Tallahassee, Fla.—*General Surgery*

LOCATIONS

Decatur County—WESTPORT—population 1,034; located 14 miles from Greensburg where hospital facilities are available. Office and residence available. Only physician in the community is past 80 years of age. Contact Mr. Richard A. Maddux, P. O. Box 177, Westport, for further information.

Sullivan County—CARLISLE—population 755 with a township population of 1,425. Farming community. Located 10 miles from Sullivan and 20 miles from Vincennes where hospital facilities are available. One physician in the community who is limiting his practice. For further information contact A. G. Callahan, Superintendent of Schools or H. Glen Berry, bank cashier, Carlisle.

Vanderburgh County—DARMSTADT—Village Square Shopping Center located approximately 10 miles north of Evansville in the small town of Darmstadt has plans for a doctor's office in a new shopping center. Growing community with approximately 1,500 homes and 6,000 persons in a four mile area. Contact Robert L. Willner, Village Shopping Center, R. R. #5, Box 242, Evansville.



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Vitamin B-2	1.2 mg.
Vitamin B-12	6.0 mcg.
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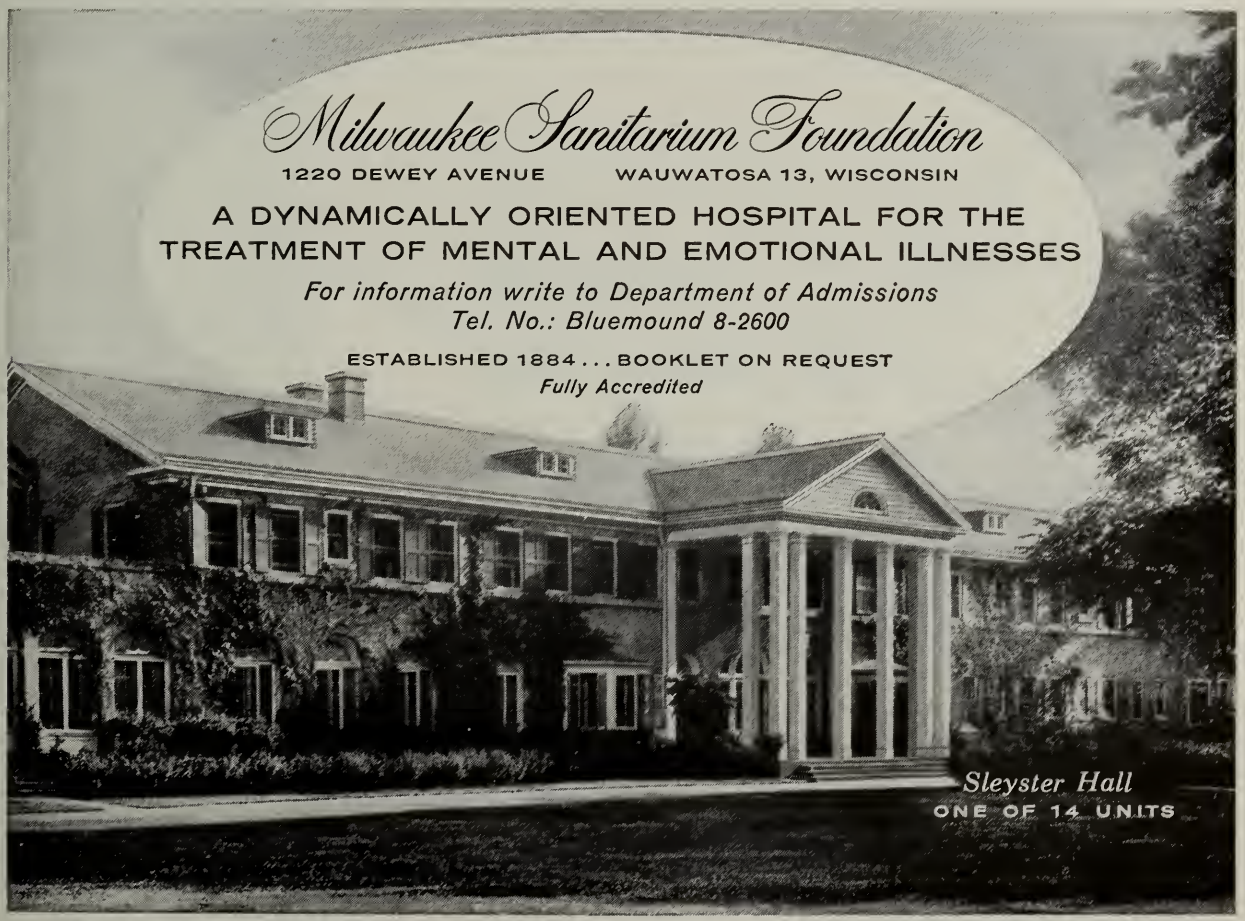
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MONTHLY REPORT — November, 1963

Disease	Nov. 1963	Oct. 1963	Sept. 1963	Nov. 1962	Nov. 1961
Animal Bites	649	692	733	526	389
Chickenpox	385	107	37	367	164
Conjunctivitis	75	23	44	85	48
Diphtheria	4	1	1	0	0
Dysentery, Unspecified	56	81	197	46	32
Gonorrhea	279	308	304	Not Available	
Impetigo	169	172	146	151	153
Infectious Hepatitis	69	43	38	55	111
Infectious Mononucleosis	38	16	10	20	10
Influenza	566	382	253	1351	544
Measles (Rubeola-Rubella)	299	123	88	140	141
Meningitis, Meningococcal	2	2	6	2	2
Meningitis, Other	6	8	8	10	4
Mumps	235	139	106	188	114
Pertussis	27	21	43	72	3
Pneumonia	131	87	99	148	142
Poliomyelitis	0	0	0	4	4
Streptococcal Infections	386	291	199	321	295
Syphilis					
Primary & Secondary	5	7	2	Not Available	
All Other Syphilis	120	168	86	Not Available	
Tinea Capitis	14	9	4	12	29
Tuberculosis (Active)	98	111	79	110	63



ABSTRACTS

BOOK REVIEWS

ORGANIZATION AND ADMINISTRATION IN WORLD WAR II

Armfield, Blanche B., M.A., Colonel John Boyd Coates, Jr., M.C., U.S.A., Editor-in-Chief, Medical Department, United States Army, U. S. Government Printing Office, Washington, 25, D. C. 613 pages, 123 illustrations, 19 charts, 14 maps and 2 tables. Price $6.25.

This is one of the volumes of the administrative series of the official history of the Medical Department of the Army in World War II. It covers the prewar emergency period with its growing problems and pains—and also the many problems so admirably met and solved in a global war.

The volume will be read with interest by physicians who served in World War II, and may be read with great profit by physicians who may serve in a military organization in the future.

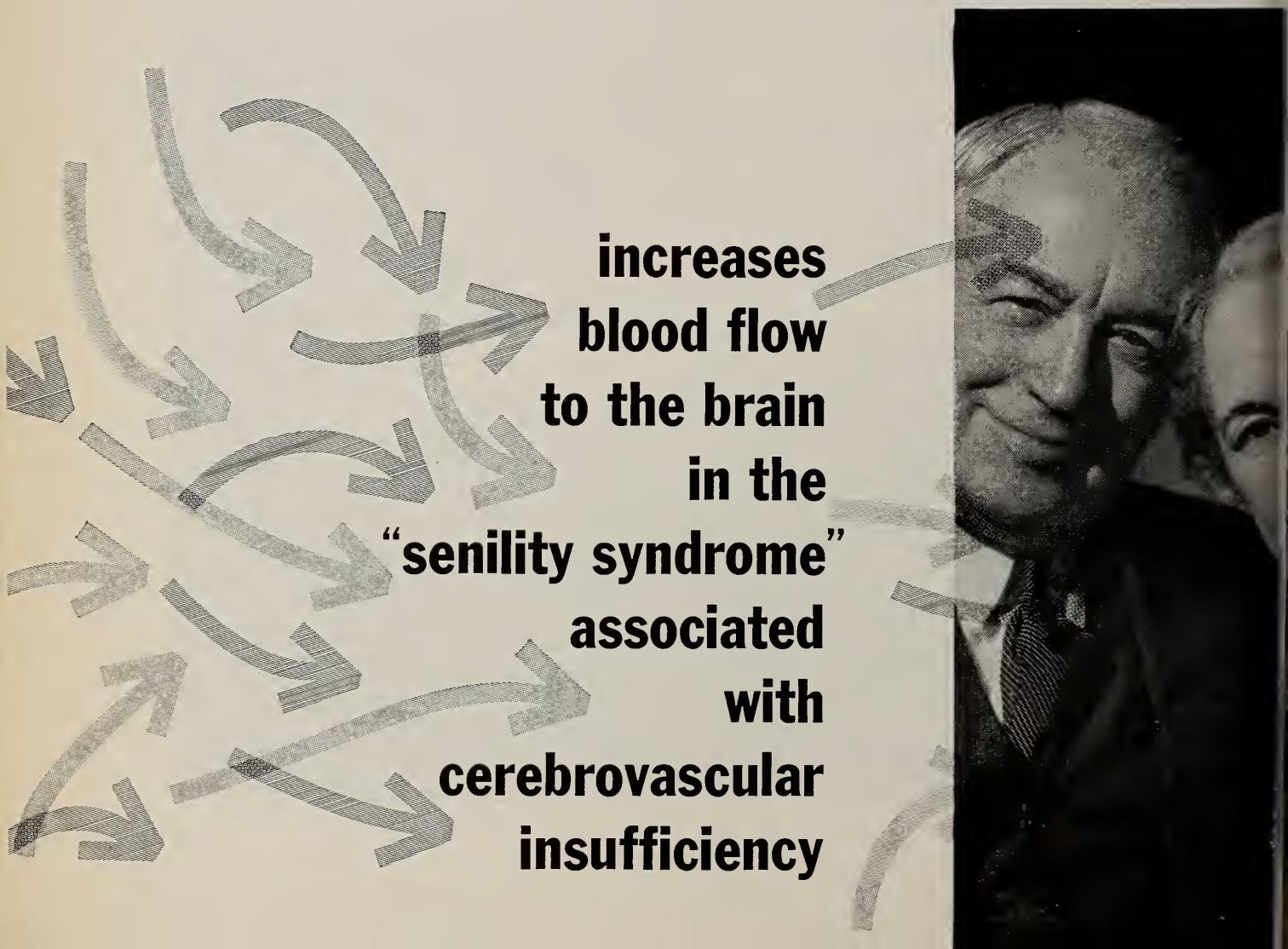
Every military unit the size of a battalion and larger should have a surgeon, responsible to the unit commander and with immediate access to the commander at all times. This principle works so well in small and medium units that it is surprising it is not always applied to large military units. It is interesting to note that the War Department did not have a surgeon during the entire war, and that the same effect was obtained in a few instances in overseas commands by the faulty organization imposed on the medical department by line officers.

While this book makes good reading for all military medical officers and physicians, this reviewer would regard it as more appropriate for general officers of the line and for Commanders-in-Chief. If the newly organized "White House Library" were to contain but one volume, this should be the one.

It is also recommended for careful reading by all officers who may be destined to become surgeons of Theaters of War—for the purpose of highlighting the tremendous success of a well staffed group of professional consultants properly organized and administered, and for the purpose of outlining the deficiencies in medical service in situations where professional consultants were misused or not used at all.

The book is well written and well illustrated. It would make good reading for any physician, regardless of military association.

FRANK B. RAMSEY, M.D.
Indianapolis



TEXTBOOK OF MEDICINE

Cecil-Loeb, Eleventh Edition. Edited by Paul B. Beeson, M.D., and Walsh McDermott, M.D., W. B. Saunders Co., Philadelphia, 1963, 1835 pages. $19.50, single volume; $23.50 2-volume set.

Dr. Cecil has just retired and the present board of editors has taken the occasion to revise completely the last edition. There are many new contributors and some half dozen assistant editors who have recast this edition into what is really an almost new textbook. The editors continue with the aim of giving the reader at least some mention of ANY disease or syndrome falling within the field of medicine!

This reviewer was reared on Osler's textbook; in the last decade or so, it is my opinion that Cecil has assumed just as an authoritative and dominating a position as had ever been held by the giants of the past. The foreword by Frank L. Horsfall, Jr., M.D., on genes and viruses appealed immensely; Dr. Kabat has written most succinctly and helpfully on immune mechanisms. The 50 new contributors have aided in bringing material up to the minute; many doubtful points in the past edition have been corrected and clarified by their authors—it is all most exciting and stimulating—TODAY with the portent of tomorrow.

Numerous illustrations, many in color, add clarity; careful pruning has made for conciseness and readability. The publishers have printed it well on excellent paper; the binding is meant for hard wear and typographical errors are notable by their absence. The two, or even three volume set is better in spite of the higher price simply because the one volume affair is just too bulky for easy handling. Whichever one gets, this volume will continue being the one single, most useful item gracing my working desk! Dr. Cecil can be proud of his choice of the men he has entrusted to carry on the living tradition he has established.

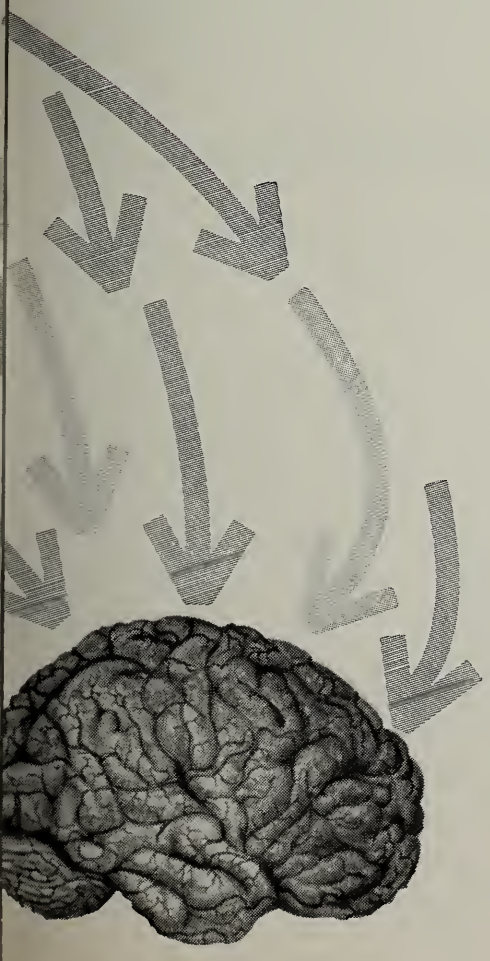
ARNOLD LIEBERMAN, M.D.
New York, N. Y.

THE PRACTICE OF COUNTRY RADIOLOGY

Bauer, Donald De Forest, M.D. Charles C Thomas, Springfield, Ill. $11.75.

Dr. Bauer has recognized the fact that the average radiologist finishing residency training today has learned very little about the actual business and mechanics of practice. His detailed discussion represents really a first of its kind. It will be valuable to residents of radiology and to those who are responsible for their training.

The title is, we believe, slightly misleading in that this book really deals with the practice of radiology wherever one finds it. Much of the very



Inadequate cerebral blood flow—often due to cerebral arteriosclerosis—may result in the "senility syndrome" with its pattern of mental confusion, memory lapses, depression, fatigue, apathy and behavior problems.[1-3]

43% increase in cerebral blood flow[4]

In patients with cerebrovascular insufficiency, Eisenberg[4] measured a 43 percent increase in blood flow in the brain following administration of Arlidin (nylidrin HCl) orally for more than two weeks beginning with a dosage of 12 mg. t.i.d. and increasing to 18 mg. t.i.d. There was a decrease in cerebral vascular resistance in most instances.

Winsor and associates[3] found Arlidin (nylidrin HCl) "of particular value **clinically** in relieving some of the symptoms of cerebral vascular insufficiency (vertigo, lightheadedness, mental confusion, diplopia)."

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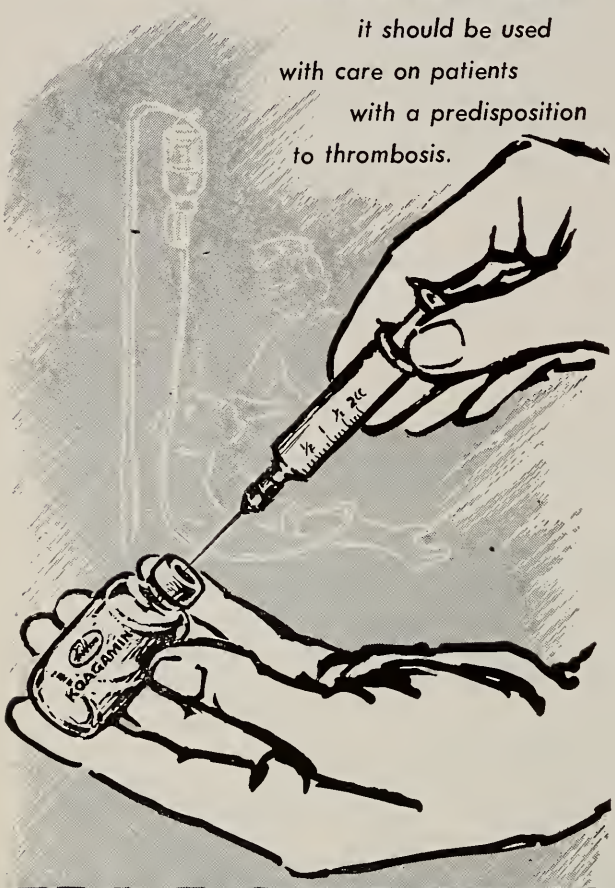
REFERENCES: 1. Madow, L.: Penn. M. J. 62-861, June 1959. 2. Stieglitz, E. J.: Geriatric Medicine, ed. 2, Philadelphia, Saunders, 1949 p. 274. 3. Winsor, T., et al.: Amer. J. Med. Sciences 239:594, May 1960. 4. Eisenberg, S.: ibid, July 1960.

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excellent material is as applicable to city practice as it is to country practice.

The obvious ideal propounded, that of helping the younger man render a better radiological service to patients and to the profession is commendable, and we believe the work makes a definite contribution toward that goal.

WALLACE D. BUCHANAN, M.D.
South Bend

CURRENT DIAGNOSIS AND TREATMENT

Brainerd, Henry, M.D., Margen, Sheldon, M.D., Chatton, Milton J., M.D. Lange Medical Publications, Los Altos, California, 1963. 834 pages, some tables, $9.50.

Purportedly a desk reference, this publication should serve its purpose well. This is a lithographic paperback with a table of normal lab values, the usual chapters, an appendix, and a good index. The appendix contains some candid opinions on unestablished and investigational drugs.

As the preface states, it is not a textbook but it is a good reference for quick information on diagnosis, differential diagnosis, treatment and prognosis. Conditions covered are those of internal medicine. Several charts are printed and a few diagrams, but no pictures.

ALVIN J. HALEY, M.D.
Fort Wayne

Abstracts From Various Literature, Prepared by AMA

EVILS OF CAMOUFLAGE AS ILLUSTRATED BY THALIDOMIDE

The outbreak of phocomelia in West Germany came to an abrupt end eight months after the public announcement that Contergan was suspected as the cause of phocomelia. Thus proving that the ingestion of thalidomide during the "sensitive period" of early pregnancy seriously injures the fetus. Lenz was able to correlate the time of ingestion of thalidomide with the type of injury to the fetus. Thalidomide has been manufactured, sold or distributed as samples in at least 26 different countries under at least 50 and possibly 100 different names. The malformation has been reproduced in New Zealand white rabbits, but not in many other animals. The difficulty of animal experiments and the importance of careful clinical tests is emphasized. Women of the child-bearing period are again warned to stay away from drugs and when necessary to take only well tested drugs upon the recommendation of their physicians.

Taussig, H. B.: Evils of Camouflage as Illustrated by Thalidomide, *New Eng. J. Med.* 269:92 (July 11) 1963.

MERITS OF REDUCING HIGH BLOOD PRESSURE

The behavior of 104 untreated hypertensive patients has been compared with that of 104 cases treated by ganglion-blocking drugs and 79 cases treated with guanethidine. All initially had diastolic pressure not less than 120 mm Hg. With treatment whether by ganglion-blocking drugs or by guanethidine the probability of dying is from 1/3 to 1/6 of that in untreated cases, the reduced mortality being due largely to prevention of the early deaths from stroke and uremia. It is suggested that both of these hazards result from arteriolar fibrinoid necrosis, the development of which is prevented or arrested by lowering the blood pressure. Fatal strokes which occur despite control of high blood pressure reflect the risk of cerebral atherosclerosis rather than of hypertension.

Leishman, A. W. D.: Merits of Reducing High Blood Pressure, *Lancet* (London) 1:1284 (June 15) 1963.

NUTRITION AND PALATABILITY

The author presents the thesis that primitive man's instinctive selection of food was mainly meat and offal and, like food selection in all species, was based on palatability. When agriculture began, economic pressure made him eat the more readily produced foods, which were rich in carbohydrate rather than in protein. The release of economic pressure has led to a tendency to revert to protein-rich foods, but this is opposed by the concurrent ability by the food manufacturer to separate food palatability from nutritional value. This current eating for palatability leads to a high intake of sugar containing foods. This is one of the chief factors in the rising incidence of obesity and dental caries and possibly also of diabetes mellitus, myocardial infarction, and peptic ulceration.

Yudkin, J.: Nutrition and Palatability, with Special Reference to Obesity, Myocardial Infarction, and Other Diseases of Civilisation, *Lancet* (London) 1:1335 (June 22) 1963.

ABNORMAL KARYOTYPE FINDINGS IN A PATIENT WITH MALIGNANT LYMPHOMA

A consistent pseudodiploid karyotype was found in a lymph node and, over a 7 1/2 month period, in six sequential bone marrow aspirates from a patient with lymphoblastic lymphosarcoma and leukocytosis. This persisted in spite of chemotherapy. There were consistently two chromosomes missing, one each in groups 6-12 and 13-15 which were replaced by a chromosome similar to pair three and an acrocentric chromosome slightly longer than pair 21. The skin and peripheral blood leukocyte culture had a normal female karyotype, indicating that the somatic karyotype of the patient was not congenitally abnormal. Chronic myelocytic leukemia was thought not to coexist with the lymphoma, since the Ph^1 chromosome was not found and the serum B_{12} and leukocyte alkaline phosphatase activities were normal.

Tijo, J. H., Marsh, J. C., Whang, J., Frei, E., III: Abnormal Karyotype Findings in Bone Marrow and Lymph Node Aspirates of a Patient with Malignant Lymphoma, *Blood* 22:178 (Aug.) 1963.

FAMILIAL ENDOCRINE ADENOMATOSIS

The syndrome of the occurrence of adenomas of one or more endocrine glands, generally of the parathyroid, pituitary, and islet cells of the pancreas, was observed in three members of one family. The father had multiple islet-cell adenomas, two parathyroid adenomas, and a bronchial carcinoma arising from an adenoma. A son and a daughter each had a single islet cell adenoma. In all three hyperinsulinism was the predominant disease manifestation. The fulfillment of the triad of (1) symptoms of hypoglycemia while fasting, (2) blood glucose less than 50 mg%, and (3) rapid relief with the administration of glucose, along with the prolongation of hypoglycemia for three hours after intravenous administration of tolbutamide, proved most helpful in the diagnosis of insulinoma.

Underwood, L. E., Jacobs, N. M.: Familial Endocrine Adenomatosis, *Amer. J. Dis. Child*, 106:218 (Aug.) 1963.

Continued

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ABSTRACTS, BOOKS

Continued

ROUTINE CIRCUMCISION

Confronted by apparently contradictory recommendations regarding "routine circumcision", two simple surveys were conducted. Among 126 sampled specialists in pediatrics, obstetrics, and urology, wide and discordant opinion was obvious. Among 80 sample mothers, even greater variation was detected. Furthermore, reasons cited as "pro" or "con" cast reasonable doubt that the decision to circumcise is reached in a scientific manner. This deplorable situation may not constitute a "medical problem," but it does constitute a "problem for medicine."

Shaw, R. W., Robertson, W. O.: Routine Circumcision, *Amer. J. Dis. Child,* 106:216 (Aug.) 1963.

SEASONAL INCIDENCE OF PEPTIC ULCER

Four hundred and eleven cases of gastroduodenal ulceration with perforation or hemorrhage were analyzed for over-all monthly and seasonal incidence. The incidence for the individual years from 1949 through 1958 were similarly analyzed and compared. The results indicate that the differences noted in the seasonal and monthly incidence were slight and probably statistically insignificant (winter 24.6%, spring 24.8%, summer 21.6%, and autumn 29.0%). When the individual years were analyzed for the seasonal and monthly incidence, there was remarkable inconsistency in the occurrence of these complications of peptic ulceration. Thus, it is concluded that complications of peptic ulcer have very slight seasonal variation, and that the incidence varies considerably from year to year.

Ahmed, S. Z., Levine, M., Finkbiner, R. B.: Seasonal Incidence of Complications of Peptic Ulcer, *Ann. Intern, Med.* 59:162 (Aug.) 1963.

ACUTE CHOLECYSTITIS IN THE POSTOPERATIVE PERIOD

In a 20-year period, 19 patients with acute cholecystitis after operations for unrelated disease were seen at Ochsner Foundation Hospital. Postoperative cholecystitis differs from the usual form of cholecystitis in several respects. It is a disease of the elderly affecting males in two thirds of the cases. Acalculous cholecystitis is more common in this group than in the usual case. Fasting and administration of opiates result in biliary stasis and, as a consequence, increased concentration of bile salts. These factors contribute to the production of acute cholecystitis in these patients. Since clinical signs are often minimal in older patients, increased alertness is required on the part of the physician if prompt treatment is to be instituted.

Knudson, R. J., Zuber, W. F.: Acute Cholecystitis in the Postoperative Period, *New Eng. J. Med.* 269:289 (Aug. 8) 1963.

SCIENTIFIC EXHIBIT APPLICATION FORM

Committee on Scientific Exhibits
Indiana State Medical Association
3935 N. Meridian Street
Indianapolis 8, Indiana

Please send me an application form for a Scientific Exhibit at the ISMA Annual Convention, October 13-15, 1964, Murat Temple, Indianapolis, Indiana.

I propose to exhibit_____

Name_____

Address_____

City_____

State_____

Art, Hobby Show Planned For ISMA Indianapolis Meeting

Space will be provided at the 1964 annual meeting of the Indiana State Medical Association, Oct. 13-15 at Indianapolis, for a Physicians Art and Hobby Show.

Members of ISMA interested in exhibiting pieces and requiring any information regarding this can contact any one of the following:

Dr. Philip T. Holland
108 W. 7th Street
Bloomington

Dr. Charles P. Schneider
2211 W. Franklin St.
Evansville 12

Dr. Truman E. Caylor
303 S. Main St.
Bluffton

Dr. Frank H. Coble
51 S. Eighth Street
Richmond

Dr. Lall G. Montgomery
Ball Memorial Hospital
Muncie

ISMA Headquarters
3935 N. Meridian
Indianapolis 8

It will be the responsibility of each physician to see that his work gets to the exhibition at the Murat Temple. Final arrangements will be taken care of by Dr. Holland and his committee.

The ISMA will provide suitable display facilities, but each physician is responsible for transportation costs and any other such expense involved in entering his exhibit.

Application for Space in Art and Hobby Show Exhibit

Mail to:

Dr. Philip T. Holland
108 W. 7th Street
Bloomington, Indiana

Name_____

Address_____ City_____

Type and number of pieces to be displayed: Photography_____

Sculpture_____

Crafts_____

Painting_____

Other_____

Estimated amount of space required—lineal or square feet_____

Other information_____

LISTEN AND LEARN

TAPES OF THE MONTH

NON-SCIENTIFIC

NS-374 **FREE ENTERPRISE OR DISASTER**—Dr. Nicholas Nyaradi, Director of the School of International Studies; former Minister of Finance, Republic of Hungary. Recorded: Indiana Farm Bureau Meeting. Date: Nov. 11, 1963.

PSYCHIATRY

P-2083 **THE INFLUENCE OF THE PATIENT UPON THE PHYSICIAN**—Louis J. West, M.D., Oklahoma City, Okla. Recorded: 114th Annual Meeting of ISMA. Date: Oct. 16, 1963. Time: 45 minutes.

P-2084 **THE PSYCHIATRIC ASPECTS OF CONVULSIVE DISORDERS**—Louis L. Tureen, M.D., St. Louis, Mo. Recorded: 114th Annual Meeting of ISMA. Date: Oct. 16, 1963. Time: 35 minutes.

CHEST AND RESPIRATORY

CR-12005 **BRONCHOSTASIS**—Albert H. Andrews, Jr., M.D., Chicago, Ill. Recorded: 114th Annual Meeting of ISMA. Date: Oct. 15, 1963. Time: 25 minutes.

CR-12006 **DIAGNOSIS AND TREATMENT OF ACUTE RESPIRATORY INFECTIONS**—Panel discussion—Roy H. Behnke, M.D., Indianapolis, moderator; Alfred S. Evans, M.D., Madison, Wisc.; Felice Manfredi, M.D., Indianapolis; Wallace Herrell, M.D., Lexington, Ky. Recorded: 114th Annual Meeting of ISMA. Date: Oct. 16, 1963. Time: 1 hour, 20 minutes.

CARDIOVASCULAR

CV-549 **THE USE OF CORONARY ARTERIOGRAPHY**—David Littmann, M.D., Boston, Mass. Recorded: 114th Annual Meeting of ISMA. Date: Oct. 15, 1963. Time: 20 minutes.

SURGERY

S-4025 **PANCREATIC PSEUDOCYST AND COARCTATION OF THE AORTA**—Harris B. Schumacker, M.D. and Indiana University residents; "Scalene Node Biopsy," Kingsley Lawrance, M.D., and a General Hospital resident; "Superior Mesenteric Syndrome", Kingsley Lawrance, M.D. and a General Hospital resident. Recorded: 114th Annual Meeting of ISMA. Date: Oct. 16, 1963. Time: 1 hour, 20 minutes.

TREATMENT

T-3057 **CHEMOTHERAPY OF CANCER**—Panel discussion—Robert J. Rohn, M.D., moderator; "Present and Future Trends in the Development of Chemotherapeutic Agents for the Treatment of Malignancies," Emil Freireich, M.D.; "Problems in the Clinical Evaluation of the Effectiveness of Chemotherapeutic Agents in the Treatment of Malignancies," John Louis, M.D.; "The Chemotherapy of Operative and Inoperative Solid Tumors," John D. Hurley, M.D.; "Treatment of Hematological Disorders with Chemotherapeutic Agents," Robert J. Rohn, M.D. Recorded: 114th Annual Meeting of ISMA. Date: Oct. 17, 1963. Time: 1 hour, 50 minutes.

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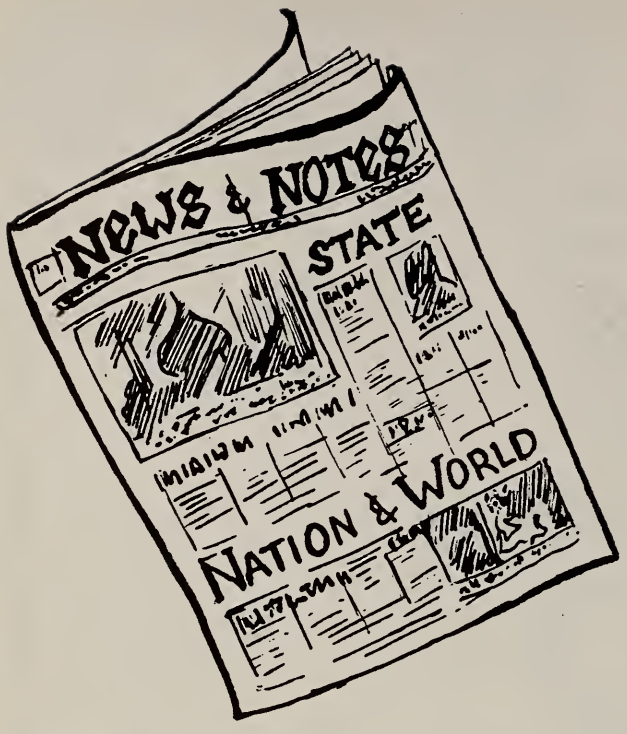
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Effective in a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill—when the offending organisms are tetracycline-sensitive. **Side Effects** typical of tetracyclines which may occur: glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis, dermatitis, overgrowth of nonsusceptible organisms. Also: photodynamic reaction (making avoidance of direct sunlight advisable) and, very rarely, anaphylactoid reaction. Reduce dosage in impaired renal function. The possibility of tooth discoloration during development should be considered in administering any tetracycline in the last trimester of pregnancy, in the neonatal period, and in early childhood. *Capsules,* 150 mg. and 75 mg. of demethylchlortetracycline HCl. *Average Adult Daily Dosage:* 150 mg. q.i.d. or 300 mg. b.i.d. 1. Sweeney, W. M.; Dornbush, A. C., and Hardy, S. M.: Demethylchlortetracycline and Tetracycline Compared. Relative *in vitro* Activity and Comparative Serum Concentrations During 7 Days of Continuous Therapy. *Amer. J. Med. Sci.* 243:296 (Mar.) 1962.

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NURSES ARE VIOLATING MEDICAL PRACTICE ACT BY CONTINUING PRACTICING WHEN PHYSICIAN IS OUT OF THE CITY

The State Board of Medical Registration and Examination of Indiana has had reports of several instances where the doctor is out of the city and his nurse, or his assistant, has continued practicing during his absence.

The board, in executive session on November 13, 1963, directed Ruth V. Kirk, Executive Secretary, to advise physicians that this is a violation of the Medical Practice Act and should be discontinued.

"Immunization of Infants and Children" Pamphlet Is Available

Immunization of infants and children is explained in an illustrated pamphlet entitled "Right From The Start—The Importance of Early Immunization."

It is Public Affairs Pamphlet No. 350 and may be obtained for 25 cents (or less in quantities) by writing Public Affairs Pamphlets, 22 E. 38th St., New York, 16. The pamphlet is intended for distribution to parents.

Pamphlet on "Retarded Children Getting Ready for School" Published

"The Retarded Child Gets Ready For School" is the title and subject of a Public Affairs Pamphlet issued recently. The advice contained in the booklet is based on the principle that "there is much that the mentally retarded child can learn, but to enable him to do so, parents and teachers must help teach him what most normal children absorb or figure out by themselves."

The pamphlet is available at 25 cents per copy from Public Affairs Committee, 22 E. 38th St., New York, 10016. Quantities are sold at lesser rates.

Dr. Hickam Named to Heart Council

Dr. John B. Hickam, Indianapolis, has been named to the National Heart Advisory Council of the National Institutes of Health.

Instructional Booklet Published On Clothing for Handicapped Children

"Self-Help Clothing For Handicapped Children" is the title of a 78-page booklet of instructions for the making of clothing, especially designed to promote the ability of a handicapped child to do for himself.

The book was printed by the Public Health Service for the National Society for Crippled Children and Adults and may be obtained at the price of 50 cents from the society, 2023 W. Ogden Ave., Chicago, 12.

Dr. Lang Speaks Before Society

Dr. Erich K. Lang, Indianapolis, spoke at the recent annual meeting of the Radiological Society of North America in Chicago. His topic was "Arteriographic Demonstration of External-Internal Carotid Anastomosis and Its Correlation to RISA Circulation Studies."

Lederle Awards in Geriatrics Are Renewed for Another Year

The Lederle awards in the field of geriatrics have been renewed for another year. Three $1,800 awards are given to medical residents to stimulate study in the medical problems of the aged.

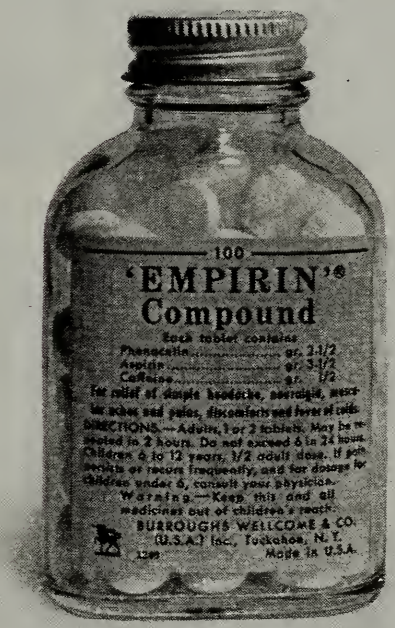
Each year also one of the three recipients of the previous year is chosen for an additional one-year award for additional work.

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*Warning—may be habit forming

Chairman, Residents and Interns Committee, American Geriatrics Society, 10 Columbus Circle, New York, 19, prior to May 1, 1964.

1963 "Immunization Information For International Travel" Printed

The 1963 edition of "Immunization Information for International Travel", a publication of the Public Health Service, may be obtained at 35 cents per copy by writing the Superintendent of Documents, Government Printing Office, Washington, 25, D. C.

Dr. Inlow Locates in Shelbyville

Dr. Robert P. Inlow, who has been a resident in surgery in the Mayo Foundation in Rochester, Minn., has located in Shelbyville, Ind.

Dr. Hamilton Elected Secretary

Dr. Charles O. Hamilton, South Bend, was elected to the post of secretary of the American Society of Anesthesiologists at its recent annual meeting in Chicago.

Harry C. Davis is Honored

Harry C. Davis, executive secretary of the St. Joseph County Medical Society, has been honored as a "Certified Professional Bureau Executive" by the Medical-Dental-Hospital Bureaus of America, Inc.

Only a few men and women from among the organization's membership have qualified for certification, conforming to exacting standards in education, experience, ethical practices, community service and similar factors as required by the group's board.

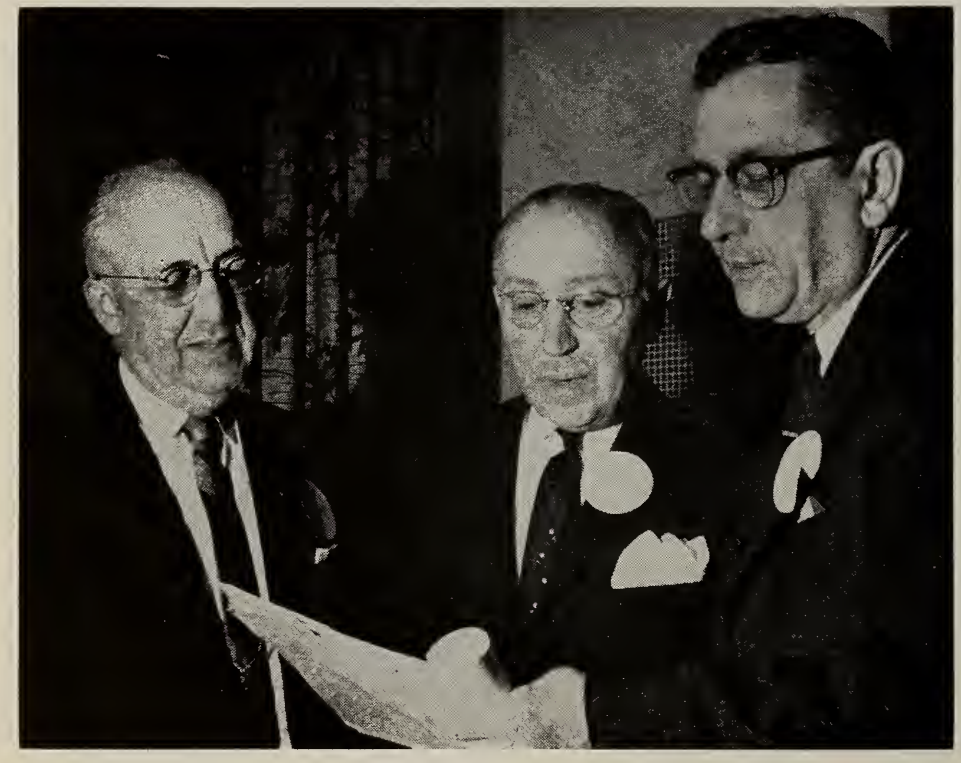
Dr. Walther Re-elected Trustee

Dr. Joseph E. Walther, Indianapolis, was re-elected a Trustee of the American College of Gastroenterology at a recent annual meeting in Washington, D. C. Dr. Roger P. Bissonnette, Evansville, was elected Governor of the College.

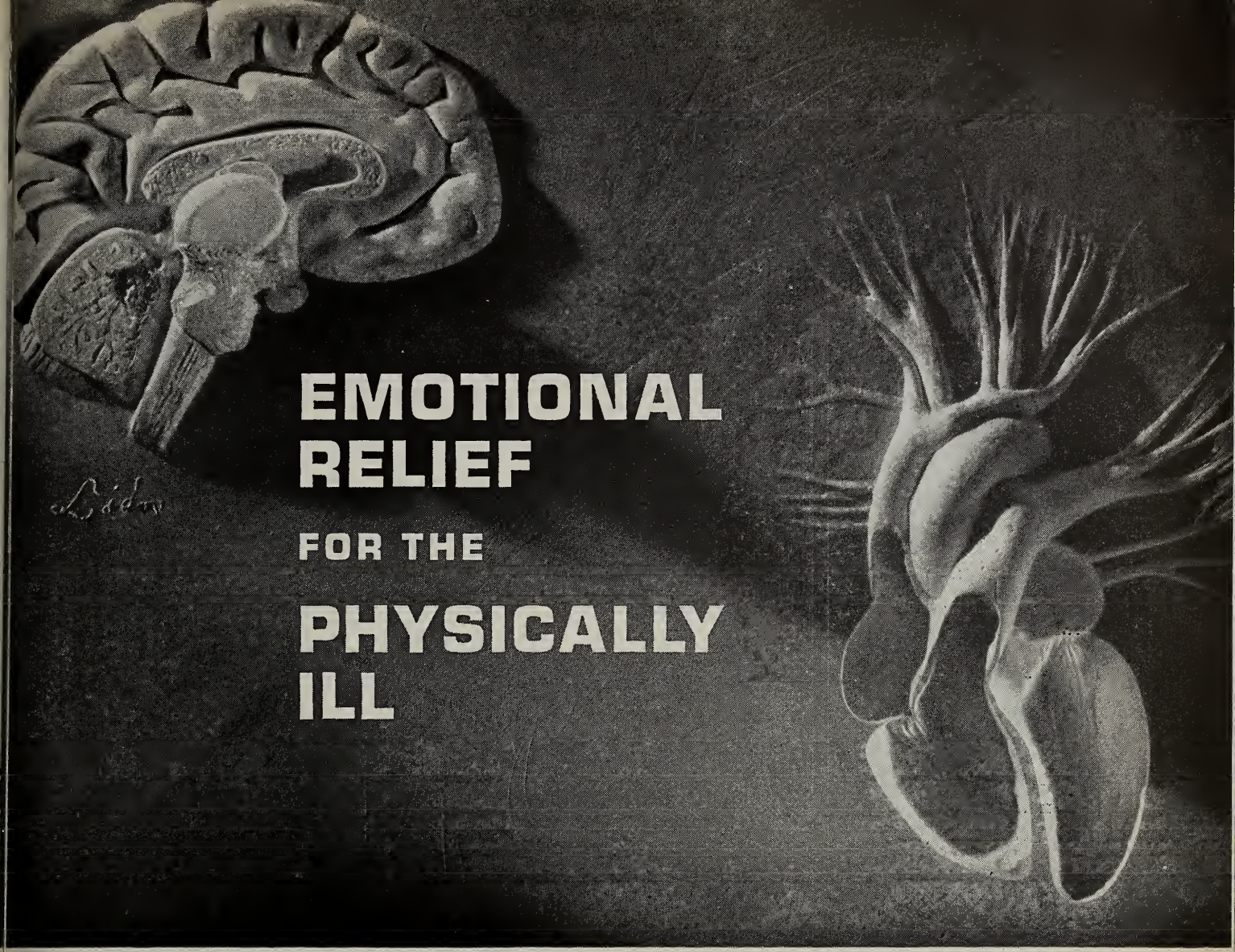
Dr. McGrath Elected Chairman

Dr. M. F. McGrath, Indianapolis, has been elected chairman of the Indiana Flying Physicians Association.

Other new officers include Drs. Robert Butterfield, Muncie, co-chairman; Dan L. Urschel, secretary-treasurer; John Paris, disaster program chairman and C. Basil Fausset, Indianapolis, safety chairman.



DR. N. L. SALON, (center) Fort Wayne physician, was re-elected chairman of the Indiana Joint Council to Improve the Health Care of the Aged at a statewide conference in Indianapolis dealing with problems of the aged. With him (left) is L. B. Gardner, D.D.S., also of Fort Wayne, who was elected secretary of the Council and F. C. Swartz, M.D., chairman, Committee on Aging, American Medical Association, who was one of the principal speakers at the all-day conference. There were 125 persons attending. The Council is composed of representatives of the Indiana State Medical Association; the state Dental Association; the state Hospital Association and the Indiana Association of Licensed Nursing Homes.



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Contraindications: Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

Precautions: Should administration of meprobamate cause drowsiness or visual disturbances, the dose should be reduced. Operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Prescribe cautiously and in small quantities to patients with suicidal tendencies. Massive overdosage may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage.

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Topics Are Announced for I. A. G. P. Annual Meeting Set for March

The Indiana Academy of General Practice has announced topics for its 1964 annual scientific session March 11-12 in Indianapolis.

The program will be divided into four sections this year for the first time. On Wednesday, March 11, the morning session will be on cancer. Wednesday afternoon, the session will be on intestinal obstruction.

The Thursday morning program will be on heart disease and vascular surgery and the afternoon sessions will be devoted to talks on diabetes.

AMA Congress on Environmental Health Problems Scheduled in May

The American Medical Association will sponsor a national Congress on Environmental Health Problems May 1-2, in Chicago.

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The Congress will deal with the physician's role in evaluating and preventing environmental health problems, with emphasis on air pollution, pesticide hazards, radiological hazards and water supply and pollution.

Dr. Raymond L. White, director of the AMA's Division of Environmental medicine and Medical Services, announced a five-fold objective for the Congress:

1. To evaluate environmental influences as contributing factors to disease.
2. To provide medical leadership in prevention programs.
3. To reduce environmental stresses.
4. To control air and water pollutants.
5. To promote local planning.

American Ob-Gyn Board Sets Dates For Oral and Clinical Exams

The next scheduled examination (Part II), oral and clinical, will be conducted for all candidates at the Edgewater Beach Hotel, Chicago, April 27-May 2. Formal notice of the exact time of each candidate's examination will be sent him in advance of the examination dates.

Candidates who have participated in the Part I examination will be notified of their eligibility for the Part II examination on or before February the first.

Current bulletins of the American Board of Obstetrics and Gynecology, outlining the requirements for application, may be obtained by writing to the secretary, 2105 Adelbert Road, Cleveland 6, Ohio.

Nine Month Cardiology Tutorial Program Scheduled in California

A nine month tutorial program in Cardiology will be offered September 15, 1964 to June 15, 1965, by the Institute for Cardiopulmonary Diseases, Scripps Clinic and Research Foundation, La Jolla, California.

This will be an intensive program covering the field of cardiovascular diseases and is especially designed for the physician in private practice who wants a year of organized instruction with freedom from

direct patient responsibility.

For details, write: E. Grey Dimond, M.D., Institute for Cardiopulmonary Diseases, Scripps Clinic and Research Foundation, La Jolla, California.

Postgraduate Course on Diseases of The Newborn Offered in May

The Department of Pediatrics, University of Cincinnati College of Medicine, will sponsor a postgraduate course on diseases of the newborn infant May 11 and 12 to be held at the Children's Hospital, Cincinnati, Ohio. In addition to a series of lectures, the course will feature bedside clinical diagnosis and treatment.

Registration will be limited to 50 physicians. The registration fee will be $75.

Address all inquiries to Dr. A. M. Mauer, the Children's Hospital, Cincinnati 29, Ohio.

Mayo Clinic Announces Clinical Reviews in March This Year

The staff of the Mayo Clinic and the faculty of the Mayo Foundation for Medical Education and Research are again presenting clinical reviews March 16, 17 and 18 and March 23, 24 and 25.

Because of the large number attending in past years, they are presenting two identical sessions on successive weeks as has been done in the past. Almost 900 physicians registered at last year's meeting.

AMA Rural Health Conference To be Held in Columbus, Ohio

The 17th AMA National Conference on Rural Health is scheduled for March 6 and 7 at the Columbus Plaza Motor Hotel, Columbus, Ohio. The theme of the meeting will be "Health in a Changing Rural Environment."

Additional details may be obtained by writing the AMA Council on Rural Health, 535 N. Dearborn St., Chicago.

Graduate Medical Assembly to Sponsor its 27th Annual Meeting

The New Orleans Graduate Medical Assembly will hold its 27th annual meeting March 2 to 5 in the Roosevelt Hotel, New Orleans.

The assembly is sponsoring a three-week Clinical Tour through Europe by air immediately after the New Orleans meeting. Full information may be obtained by writing Dr. Friedrichs H. Harris, 1430 Tulane Ave., New Orleans.

Obstetric Problems in Private Practice Course Set for February

Obstetric Problems in Private Practice, an intensive short course to be held at the Medical College of Georgia February 18-20, 1964, is designed especially for physicians in general practice who are interested in improving their skills in the private practice of obstetrics.

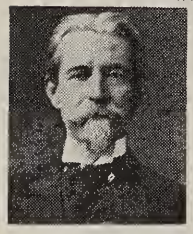
The course will consist of a review of current concepts in the management of selected prenatal complications, supportive care in labor and delivery, and management of the puerperium. Movies will be shown. Ample time will be allotted for open discussion. Case presentations will be used, including cases presented by the course participants. Each course is acceptable for 18 hours credit by the American Academy of General Practice. Registration is limited to a small group for close faculty—participant communication. Registration fee is $50.00. Application can be made by contacting Dr. Claude-Starr Wright, Director, Department of Continuing Education, Medical College of Georgia, Augusta, Georgia.

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3108 Burnet Avenue, Cincinnati 29, Ohio
Fairfield at Pontiac, Fort Wayne, Ind.
416 N. Main St., Evansville, Ind.

The Journal Welcomes New ISMA Members

Clare M. Assue, M.D., *Psychiatry*, Howard University, 1954. (Marion)

Barton C. Bridge, M.D., *General Practitioner*, University of Iowa, 1950. (Tippecanoe)

David J. Buddrus, M.D., *Nutrition*, Creighton University, 1947. (Vanderburgh)

Wilbert Washington, M.D., *Ophthalmology*, Meharry Medical School, 1958. (Marion)

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County News

Allen

A panel discussion on "Use of the Artificial Kidney" highlighted the Nov. 5th meeting of the Allen County Medical Society. Speakers included Drs. George M. Hamilton, James P. Scudder and August N. Tomusk.

Boone

Dr. Arthur Baptisti, Indianapolis, showed a film and slides of his trip on the U.S.S. Hope before the Boone County Medical Society meeting Dec. 3rd.

Clay

Field Secretary Robert Amick discussed problems of medicine and government with the 10 members of the Clay County Medical Society present at the Nov. 26 meeting.

Decatur

Ten members of the Decatur County Medical Society met Nov. 22 at the Decatur County Hospital to discuss the sales tax and the Washington situation with Field Secretary Amick.

Delaware-Blackford

Dr. Robert C. Peacock has been elected president of the Delaware-Blackford County Medical Society for 1964. Other officers elected at the Nov. 19th meeting are Drs. Warren Bergwall, president-elect; Donald R. Taylor, secretary and Lawrence Benken, treasurer. All of the new officers are from Muncie. Delegates will be Drs. Thomas Brown, Glynn A. Rivers and Dean Jackson. Alternates will be Drs. Philip Ball, Clyde Batkin and Richard Ingram.

Elkhart

Dr. Walter Compton presented a program on Japan before the Elkhart County Medical Society meeting Dec. 5.

Hendricks

The Hendricks County Medical Society met Nov. 12 at the Hendricks County Hospital. There were 16 members present.

Henry

Twenty members attended the Nov. 21 meeting of the Henry County Medical Society. Field Secretary Amick discussed the new sales tax in detail with the physicians present.

Huntington

The Huntington County Medical Society met Nov. 19 to hear a clinico-pathological conference conducted by Drs. Paul Doermann and Charles Aust. There were 18 members present.

Jay

Dr. Karl Manders Indianapolis, discussed a film on chemopallidectomy with the 12 members of the Jay County Medical Society present at the Nov. 6 meeting.

Jefferson-Switzerland

The Jefferson-Switzerland County Medical Society met Nov. 5 in Madison. There were 22 members present.

Kosciusko

Dr. William Cron was installed as president of the Kosciusko County Medical Society at its Nov. 19 meeting. Other newly installed officers include Drs. Carl Shrader, vice-president and Edgar Reed, secretary-treasurer. All of the new officers are from Warsaw.

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Madison

The Madison County Medical Society had a symposium on trauma at its Nov. 18 meeting in Anderson. Drs. William R. Kopp and William O. Starks were the speakers.

Montgomery

Dr. Herbert L. Sedam, Indianapolis, showed color slides and discussed the three month period he spent in the Congo with the Montgomery County Medical Society at its Nov. 21 meeting. There were 25 members present.

Parke-Vermillion

The Parke-Vermillion County Medical Society met Nov. 20 at the Vermillion County Hospital with 25 members present.

Rush

Twelve members of the Rush County Medical Society met Nov. 14 at the Rush County Hospital with Field Secretary Amick.

Shelby

"The Clinical and Laboratory Aspects of Thyroid Disease" was the topic chosen by Drs. L. H. Kornafel and R. L. Costin, both of Indianapolis, when they spoke before the Shelby County Medical Society meeting December 4. The society also elected new officers at this meeting. Serving as new officers for the next year will be Drs. William L. Green, president; Joseph Moheban, vice-president and P. M. Inlow, secretary-treasurer.

Tippecanoe

The Tippecanoe County Medical Society met Nov. 12 in conjunction with the local clergy to hear the Rev. Dr. Paul B. McCleave discuss the new AMA department he heads, the Department of Medicine and Religion. There were 94 members and clergymen present.

Vigo

The Vigo County Medical Society met Nov. 12 in Terre Haute with 22 members present.

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Deaths

Pearl B. Combs, M.D.

Dr. Pearl B. Combs, 77, died Nov. 4 at Evansville as the result of injuries suffered in an auto accident.

Dr. Combs, retired surgeon, was made a member of the ISMA 50-Year Club in 1961. A 1911 graduate of the University of Louisville, Dr. Combs was a World War II veteran, on the staffs of all three general hospitals in Evansville and a member of the Vanderburgh County Medical Society.

Merle D. Gwin, M.D.

Dr. Merle D. Gwin, retired physician and surgeon, died the latter part of October at Miami Beach, Fla. He was 84.

Dr. Gwin, a member of the ISMA 50-Year Club and the Jasper-Newton County Medical Society, retired in 1945. He was formerly the health commissioner of Jasper county and Rensselaer coroner for 10 years.

Stanley J. Klos, M.D.

Dr. Stanley J. Klos, 39, died November 25 in Valparaiso. A graduate of the I. U. School of Medicine in 1954, Dr. Klos was a member of the Porter County Medical Society and a former member of the Lake County Medical Society.

Clarence D. Mendenhall, M.D.

Dr. Clarence D. Mendenhall, retired physician, died Nov. 11 at his Indianapolis home. He was 66.

Born at Winchester, Dr. Mendenhall was a graduate of the I.U. School of Medicine. He practiced at Jasonville before coming to Indianapolis six years ago. He was formerly a member of the Marion County Medical Society.

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Roster: $3.00 each.

Yearbook: $5.00 each.

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Commercial announcements are carried in the Journal as a special service to ISMA members. Only advertisements considered to be of advantage to members by the Journal editorial board will be accepted. Those of a truly commercial nature (i.e., firms selling brand products, services, etc.) will be considered for display type advertising.

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By H. J. REUTER, M.D., Private Urologic Hospital, Stuttgart, Germany. Translated by HUBERT G. W. FROHMÜLLER, M.D., Fellow in Urology of the Mayo Clinic, Rochester, Minnesota. 114 pages, 6⅜″ x 9½″, with 178 figures, 105 in color. About $15.00. *New—Just Ready!*

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Volume I published January, 1963 (Esophagus and Stomach). Volume II Just Ready (Intestines, Colon and Peritoneum). Volume III Ready September, 1964 (Liver, Biliary Passages, Gall Bladder, Pancreas). This is the *New (Second) Edition* of a monumental work on *all known primary and secondary disorders of the digestive tract and its appendages.* Each disorder is discussed in a logical pattern: causative factors, clincial features, diagnostic aids, differential diagnosis and therapy. Illustrations are used lavishly. Many are in vivid color. Included in the two volumes now completed you'll find new chapters on: *Oral Manifestations of Internal Disease; Tests Employed in the Study of Esophageal Function; Protein-Losing Gastroenteropathies; The Acute Abdomen; Peritoneoscopy; Lymphangiography; etc.* You'll find a new section of endoscopic views of the esophagus and stomach in magnificent color. This revision incorporates all the advances made in the fields of cytology, radiology and biochemistry as they relate to gastroenterology. Newer and more effective methods of therapy are evident throughout.

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February 1964

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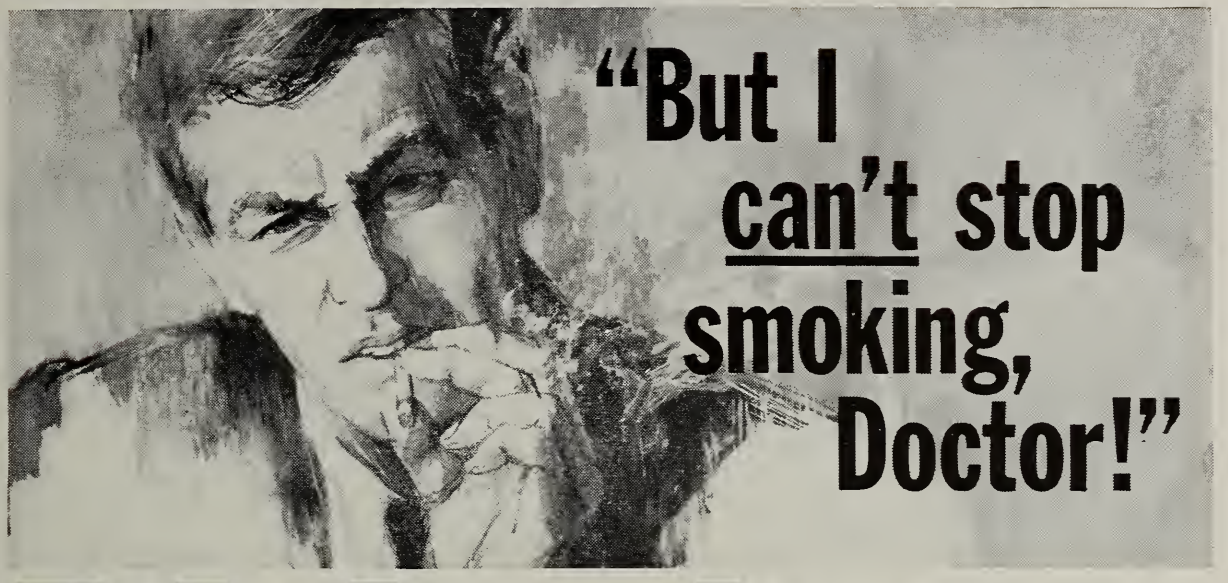
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10% of income limitation on the amount of retirement savings an individual with employees could use for tax deduction purposes. This would be a tremendous boost for the Keogh program and for self-employed persons with retirement savings plans.

Rep. Eugene Keogh (D., N.Y.) and Sen. George Smathers (D., Fla.) are sponsoring the amendment.

The Internal Revenue Service recently issued a tentative ruling that was a setback to physicians and other professional men planning to band together into corporations for tax purposes. A proposed regulation stated that such professional organizations must have all of the characteristics of a business corporation in order to qualify for corporation tax treatment, which would be virtually impossible for a group of professional men.

The regulation would knock out the so-called Kintner regulations of 1960 under which IRS stated that associations of professional men would be classified for tax purposes as corporations provided certain corporate characteristics were followed and provided that state law authorized establishment of the groups as corporations.

The IRS proposal is not final and will be the subject of hearings at a later date. It appears certain to be the subject of court litigation, if made final.

—A civil defense bill that has passed the House and is before the Senate. It would provide a $190 million program of grants to hospitals and other non-profit institutions for building fallout shelters. These shelters could be used as garages, storage areas, etc., in peacetime.

—An Administration proposal to require clearance and approval of new medical devices, which means anything from a new type of forceps to the most complicated radiation device. FDA would rule on the efficacy as well as the safety of such devices, as it does now on new drugs.

—"Humane" treatment of laboratory animals. Most of such bills would require research institutions to provide laboratory animal care conforming to certain fixed federal standards in order to qualify for federal grants.

—An amendment to the medical education law that would forgive part of the repayment of federal loans to students if the young physician settles in a physician-shortage area.

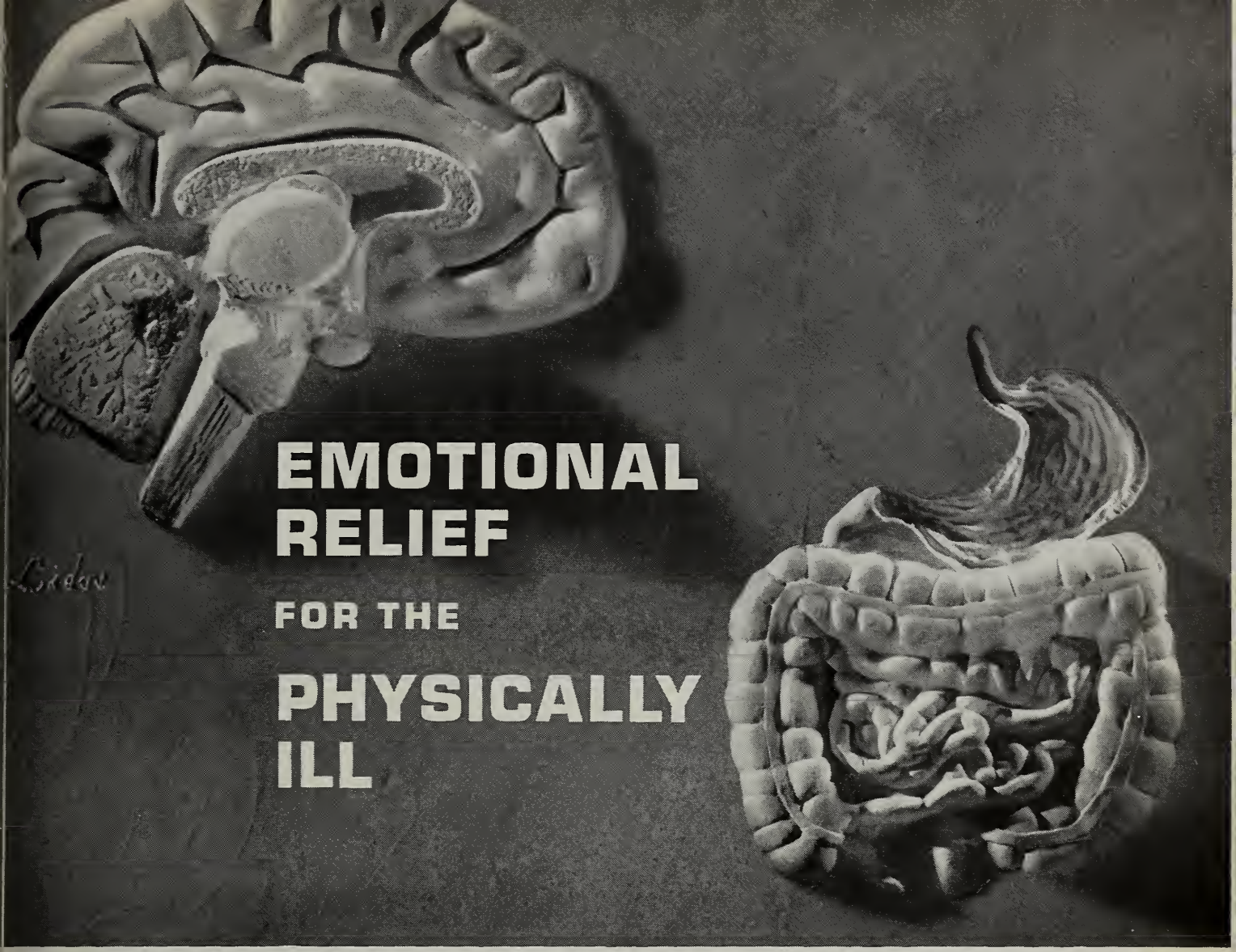
—The American Medical Profession and the U.S. Public Health Service have joined forces in opposing a Senate-passed bill that would deprive PHS of its authority over water pollution control activities. The bill, now before the House Public Works Committee, would set up a separate organization in the HEW Department to handle this function. The AMA contends that this would subordinate the health aspects of water pollution.

MEDICAL RESEARCH AN INVESTMENT

—Appropriations for the National Institutes. Last year Congress cut the NIH budget request by $12 million in approving $918 million for NIH. This was the first time in recent years Congress has failed to substantially increase the NIH budget request of the Administration. It indicated that Congress is going to take a closer look at all federal projects, which total some $14 billion a year.

The AMA has pledged its aid to a Special House Committee investigating

Continued



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Continued

the Federal research effort. The AMA told the committee that medical research spending should not grow to the point where quality is overlooked in favor of quantity.

"Research is an investment in the future," Dr. F. J. L. Blasingame, Executive Vice-President of AMA, said in a letter to the committee. "Properly conducted and supported by prudent expenditures, medical research, providing for his physical and social well-being, is vital to the total health security of man . . .

"Certainly, the effort of your Committee and the review being conducted should prove helpful to the nation. We would like to aid that effect in every way that we can."

AIR POLLUTION PROGRAM

President Johnson signed into law a bill authorizing $95 million over the next three years to help states and local agencies combat air pollution, including that from automotive exhausts and industries.

The new law revised the old air pollution control program and makes it permanent. It expands the 1955 program that provided Federal grants for cooperative research under the direction of the Secretary of Health, Education and Welfare. He was given broader authority for such research and directed to recommend remedial actions.

These remedial actions could include Federal suit for abatement of interstate air pollution. The Attorney General also could aid states in such intra-state actions if aid were asked by the governor and other state officials.



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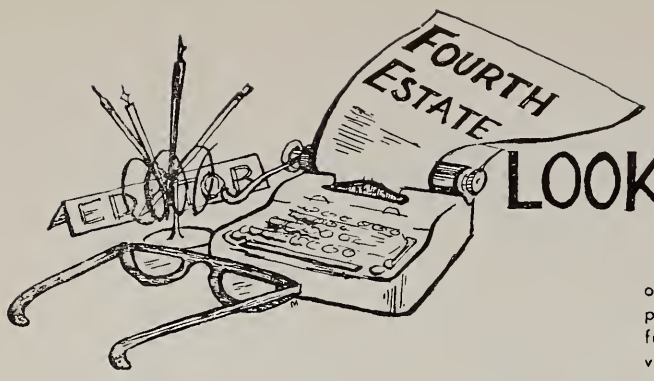
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LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Medical School Decision Has Deadline

There is a certain amount of urgency in the campaign to locate a state medical school in Evansville.

The state has a year and one half, at the outside, to make up its mind whether such a school will be built, and what it will cost. It seems almost certain that a cost estimate would have to include a site decision.

July 1, 1965, is the deadline for applications for a new program of Federal grants for construction of medical, dental, pharmacy, and nurses training schools. The Federal Government has authorized spending of $175 million for the program. Up to $2 in Federal money will be available for every dollar the state appropriates for a major expansion of training capacity.

At least one major provision of the bill bolsters Evansville's case. It requires the surgeon general to consider the geographical distribution of facilities and availability of facilities and health personnel per local population.

Thus the fact that Evansville is some distance from the nearest medical school is a persuasive argument. Not only does it indicate the need for such a facility, but it will be a strong point for the state in dealings with the Federal Government.

The argument, of course, is valid only if an Evansville medical school here would be feasible in other respects. Thus there is an urgent need for just the sort of data gathering that a local committee has been discussing. A great deal of co-operation will be required, especially from hospitals, medical societies, and government officials, to get all of the information that is needed.

The situation is in some ways reminiscent of the campaign for location of Interstate 64 through southern Indiana. There were strong feelings about each proposed location. But depth of feeling and oratorical ability had little to do with the final decision. Rather, it was a matter of which group presented conclusive facts.

This probably will be the case in regard to the proposed medical school, too. At any rate, the need for a detailed study, made in plenty of time for state consideration, appears to be clear-cut—*Evansville Courier,* Nov. 30, 1963.

Medicare: Burden For The Future

Under the Medicare plan suggested by the National Committee on Health Care for the Aged, anyone unfortunate enough to become ill or injured after 65 would find himself in a two-to-one minority position.

The plan, endorsed by New York's Republican Senator Jacob Javits and New Mexico's Democratic Senator Clinton P. Anderson, would make his medical bills the three-way responsibility of the Federal Government, a private health insurance monopoly and himself. Rich or poor, that's the position he would be in.

The old King-Anderson approach to Medicare, under which Social Security hospital charges would be partly met by Social Security, never acquired wide enough support to become law. Senator King's still plugging for it, but it looks like Senator Anderson has defected to follow this new suggestion.

In some ways, the new plan is worse than the old. A separate Social Security fund would be set up, and we'd all be taxed to build and support it. Private health insurance companies, which now compete vigorously and which are under competitive

Continued on page 112

pain is almost invariably a presenting symptom in cases of skeletal muscle *spasm*

In some instances, the pain subsides on relaxation of the muscles in spasm. In others, relaxant therapy alone fails to give adequate relief, and supplementary analgesia (and possibly sedation) are indispensable, as in cases of:

provocative pain, when muscle spasm is triggered by some painful underlying musculoskeletal defect.

residual pain, when relaxation of severe spasticity leaves a degree of myalgia that tends to reinvoke spasm.

severe pain, when the degree of pain is such as to cause persistence of symptoms in spite of relaxant therapy.

emotionally aggravated pain, when anxiety or agitation creates tension that thwarts the efficacy of both relaxant and analgesic medication.

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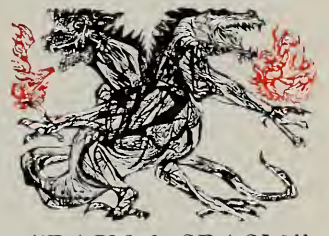
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Continued from page 108

pressure to keep their costs down and their coverage up, would be exempted from the anti-trust laws and forced into identical molds in dealing with the aged.

The ailing elderly would have two bureaucracies to deal with, rather than one. None of those who already are retired have contributed a dime to such a service, and no one who retires in the next decade will have contributed substantially to it. Yet, regardless of need, all Social Security recipients would be eligible.

A worker who retires today stands to collect several times the amount of his contributions to Social Security, even without any new benefits. A young person who takes his first job today can expect to pay $1.60 to Social Security for every dollar he may expect to draw from it when he retires, as a direct result of these early operations of the system.

There are many ways in which medical needs of the elderly needy are met, and no one would mind improving them. But why load more of one generation's bills on another generation regardless of need?—*Bloomington Herald-Telephone*, Dec. 2, 1963.

City on Verge of Second Renewal Project

Evansville is embarking on a second redevelopment project just as its first is about completed.

Redevelopment of the area around Baptist Hospital as a medical center, is expected to be under way by the middle of 1964. If everything goes as expected, the High Street slum clearance project should be closed out at about the same time.

The final settlement will involve a net cost of about $900,000 to the Federal Government for the entire project. The net cost to the city is expected to be about $450,000.

Whether it was worthwhile depends upon individual viewpoint. The project is hard to justify simply on the basis of tax yield. Property taxes paid by industries in the High Street area, redevelopment officials point out, are already far above the amount paid by former owners. But even if the difference were $30,000 a year, an amount not yet attained, it would take 45 years for tax yield to equal the total Federal-city cost of the project. It would take 15 years for the city to recoup its costs alone, disregarding the possibility of private development if the project had not materialized.

The arguments for redevelopment must rely on indirect benefits. Some are persuasive. It costs less to give police and fire protection to the glistening new commercial buildings than it does to the former hodgepodge of run-down apartments and stores. There are new employment opportunities. Evansville as a whole is a better place to do business because the High Street clutter is removed. And there is the purely psychological effect of having downtown border a new, busy warehouse-wholesale-commercial district rather than a slum.

The second project differs in important respects from the first. The net cost will be smaller—about $540,000 in all. Because of provisions allowing the city to take credit for money Baptist Hospital spends on expansion, the city's cost will be only $14,500—an amount that can be regained in increased tax payments in a few years.

Like the High Street project, the medical center redevelopment provides a method of clearing enough property, all at the same time, to change the face of an entire neighborhood. And like the High Street project, there are important fringe benefits to the city.

The whole concept of slum clearance as a tool for improving our cities is still in the formative stage. Undoubtedly, there will be modifications on the basis of experience.

Meantime, the medical redevelopment plan promises a worthwhile addition to community facilities, at a nominal cost to the city government. It should be pursued promptly and vigorously.—*Evansville Courier*, Dec. 2, 1963.

University Development Falling Behind Need

The presidents of Indiana's four state-supported colleges and universities are wondering how their institutions are going to accommodate a rush of post World War II babies into the ranks of college students next year.

The presidents, Elvis J. Stahr jr. of Indi-

ana University, Frederick L. Hovde of Purdue, John R. Emens of Ball State, and Raleigh W. Holmstedt of Indiana State, met last week at the I.U. Medical Center in Indianapolis to discuss the problem with newsmen. Their chief fear is that quality of education may be weakened.

Already crowded to the rafters, I.U. expects a 25% increase in freshman enrollment next year and more in 1965. Dr. Stahr said total enrollment has climbed steadily with no rise in freshman enrollment up to now. He explained that recent high school graduates are better equipped for college and thus stick it out. The normal attrition has decreased significantly.

The schools were granted only about half of the funds sought from the last General Assembly for new facilities. They failed to receive even the sharply reduced appropriations pending the outcome of litigation over the sales tax and are hopelessly behind on their construction timetables.

About $4 million in Federal funds will be available when President Johnson signs a college construction bill passed by the Senate Tuesday [Nov. 26, 1963]. But at present, the state schools don't have the necessary 2-to-1 matching dollars.

There's nothing for the presidents to do now but try to improvise to get through the crisis.

They have scheduled more classes, operated labs in shifts, and suspended temporarily the drive for new programs they believe necessary for education in the Space Age. I.U. has even "borrowed" a girls' dormitory for classrooms and administration offices.

Tuition rates have been raised to the point where "public education is in danger of being no longer public," Dr. Stahr believes.

These stopgap measures will not solve the problem, however. New equipment is needed, new buildings are a must and others need replacing. Dr. Stahr said I.U., now more crowded than the national average, is using a large number of Quonset huts that have outlived their usefulness and are standing "only because the termites are holding hands."

It is apparent that only adequate funds can enable our state universities to remain competitive in obtaining and keeping qualified faculty, and in educating students who can meet the challenges of this technical new age.

Relief seems a long way off, but the need is immediate.—*Evansville Courier,* Dec. 1, 1963.

Physician Population Grows

It is periodically charged that the number of practicing physicians in this country is not large enough to meet the need and the demand for medical services.

If such a fear has any validity at all, it would seem that the lack is being rapidly made up. The American Medical Association recently reported that the ratio of doctors per 100,000 population has increased from 137.8 to 146.7 in only three years. There is every reason to believe that the trend will continue. More students are enrolled in our medical schools than ever before, and this year's graduating classes totaled the highest in history. The number of those schools has grown from 77 to 87 in 17 years, five more are to be built shortly, and another six are in the planning stage.

The AMA News urges that physicians contribute to the future of medicine by giving guidance and inspiration to secondary school students who may be considering medical careers and must soon make a positive or negative decision. In its words, "By assisting these schools in their search for dedicated and well qualified students, today's physicians can assure a strong profession and a healthy America for tomorrow." No one who knows the caliber of the medical profession will doubt that such a challenge will be met.

So, there would seem to be no grounds for believing that the standards of medical care in this country, which certainly are not surpassed anywhere, will suffer. There is, on the other hand, every reason for believing that those standards, aided by new discoveries and technics, some of a literally revolutionary character, will surely improve.—*Muncie Press,* Dec. 16, 1963.

Letters

to the editor

To The Editor:

The Superior Court of Pennsylvania on January 16, 1962, handed down an opinion in a case entitled Alexander v. Knight, which appears in 177 *Atlantic Reporter*, 2nd Series, at page 142, which I think is interesting and instructive to lawyers and doctors. I quote from the opinion at page 146:

> "Dr. Ezickson apparently is a physician who is employed by defense attorneys to interview doctors for injured plaintiffs and to secure a report from them. He secured such report from Dr. Murtagh and he paid Dr. Murtagh $50 for the report. *This report was given despite the fact that Dr. Murtagh never received his patient's permission to give such report or information.*
>
> "(1,2) We do not consider the entire Ezickson matter as significant in this case, but we deem it advisable to briefly refer to our view of this incident. We are of the opinion that members of a profession, especially the medical profession, stand in a confidential or fiduciary capacity as to their patients. They owe their patients more than just medical care for which payment is exacted; there is a duty of total care; that includes and comprehends a duty to aid the patient in litigation, to render reports when necessary and to attend court when needed. That further includes a duty to refuse affirmative assistance to the patient's antagonist in litigation. The doctor, of course, owes a duty to conscience to speak the truth; he need, however, speak only at the proper time. Dr. Ezickson's role in inducing Dr. Murtagh's breach of his confidential relationship to his own patient is to be and is condemned."

The reason I believe this is important to call to your attention is that I think a great many doctors in Indianapolis are imposed upon by attorneys in the same manner as Dr. Ezickson imposed upon Dr. Murtagh. In a large percentage of the cases which I have handled, I know that it is the practice for the attorneys on the other side to contact the doctor for my client in person or by telephone and pry a lot of confidential information out of him. This is not only a disservice to their patients but to themselves indirectly because it lessens my chance of recovering the damages to which the patient is entitled and thereby be better able to pay the doctor for his services.

As the opinion says, "the doctor, of course, owes a duty to conscience to speak the truth; he need, however, speak only at the proper time." The proper time would be only in the event he had a written authorization from his patient authorizing him to speak or when he was in court in response to a subpoena, at which time his patient's attorney can claim privilege and prevent him from speaking or he can waive the privilege and allow the doctor to speak.

Yours most sincerely,
Earl C. Townsend, Jr.,
Attorney-at-Law

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The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Supervised by THE COUNCIL

Volume 57 — February 1964 — Number 2

Recent Advances in the Management of Stokes-Adams Disease

CHARLES FISCH, M.D.*
Indianapolis

STOKES-ADAMS DISEASE is defined as episodes of disturbed central nervous system function varying from giddiness to actual convulsions, complicated by a high degree of atrio-ventricular (A-V) heart block. Essentially the symptoms are due to insufficient perfusion of the brain secondary to one of the following three mechanisms: (1) Complete heart block with an idioventricular rate so slow that the cardiac output is insufficient (2) complete heart block or changing degree of heart block with episodes of ventricular standstill or (3) heart block with attacks of ventricular tachycardia, flutter or fibrillation.

The use of drugs such as atropine, steroids, isoproterenol, ephedrine, aqueous epinephrine and occasionally epinephrine in oil for prevention of recurrent episodes is well known and described in standard textbooks; for this reason it is not included in the present discussion of management of Stokes-Adams disease. We will stress two recent major therapeutic advances, namely prolonged intravenous use of isoproterenol and epinephrine and electrical stimulation of the heart.

If prolonged periods of ventricular standstill or fibrillation are the primary manifestation of Stokes-Adams disease, then the immediate aim is to restore circulation to the brain. This must be done within the critical period of four minutes after cardiac arrest. The steps to be taken in this situation are the same as for any episode of cardiac standstill, and these are familiar to all physicians.

Patient's with Stokes-Adams disease should be hospitalized to determine, if possible, the etiology of the heart block. While in the hospital the individual can be connected to a combination monitor, pacemaker and defibrillator and, when necessary, the optimal heart rate can be maintained by external stimulation or countershock used in case of ventricular tachycardia or fibrillation.

Use of Drugs for Suppression

Zoll (*Circulation* 27:5, 1963) pointed out that both cardiac standstill and ventricular arrhythmia can be prevented by intravenous use of isoproterenol or epinephrine. He

*From the Department of Medicine and Heart Research Center, Indiana University School of Medicine; the Krannert Heart Research Institute, Marion County General Hospital, Indianapolis.

Supported by the Herman C. Krannert Fund, the Indiana Heart Association, Indiana State Board of Health and (in part) by the U. S. Public Health Service Training Grant 5363 and (in part) with facilities provided by Cardiovascular Clinical Research Center Grant H-6308 from the National Heart Institute, National Institutes of Health, U. S. Public Health Service.

suggests that the paradoxical suppression of arrhythmias by a drug, which under certain circumstances can actually produce such disturbances of rhythm, is probably due to acceleration of the "primary" idioventricular rhythm to a point where the "primary" pacemaker suppresses the ectopic ventricular activity. The choice between isoproterenol and epinephrine is based on their effect on blood pressure. If elevation of blood pressure is desirable, epinephrine may be used; if, however, such a side effect is undesirable, isoproterenol is the drug of choice. The drugs are given in dilution of 4 mg per liter of fluid and administered at a rate of 15 to 30 drops per minute. Ideally the idioventricular rate should range between 35 and 40 beats per minute. A rate above 40 due to administration of these drugs may produce ventricular tachycardia or fibrillation. This form of intravenous therapy may be continued for hours or days.

Failure of the symptoms to respond to the above management suggests that some means of electrical stimulation may be necessary. As an interim procedure, a catheter-electrode may be passed via the jugular vein and located at the outflow tract of the right ventricle and attached to an external pacemaker. The heart can then be stimulated until a permanent internal electric pacemaker is implanted (Figure 1). This procedure, however, should not be used for prolonged periods of time because complications such as thrombosis or endocarditis may occur.

Patients considered for implantation of internal electric pacemakers should be carefully evaluated. Individuals with complete heart block and Stokes-Adams disease following acute myocardial infarction should be treated with drugs because most often the block is transient in character and even if it does become permanent and symptomatic, surgical implantation should if at all possible be postponed for three to six months following the infarction.

Because of the poor prognosis of Stokes-Adams disease treated with drugs and the inability to predict the course of these patients, the use of internal pacemakers, despite the obvious limitations of the instruments, is definitely indicated in patients who have symptoms despite drug therapy, in patients where refractory heart failure is thought to be partly related to the slow heart rate and in patients who by virtue of slow rate alone, without compli-

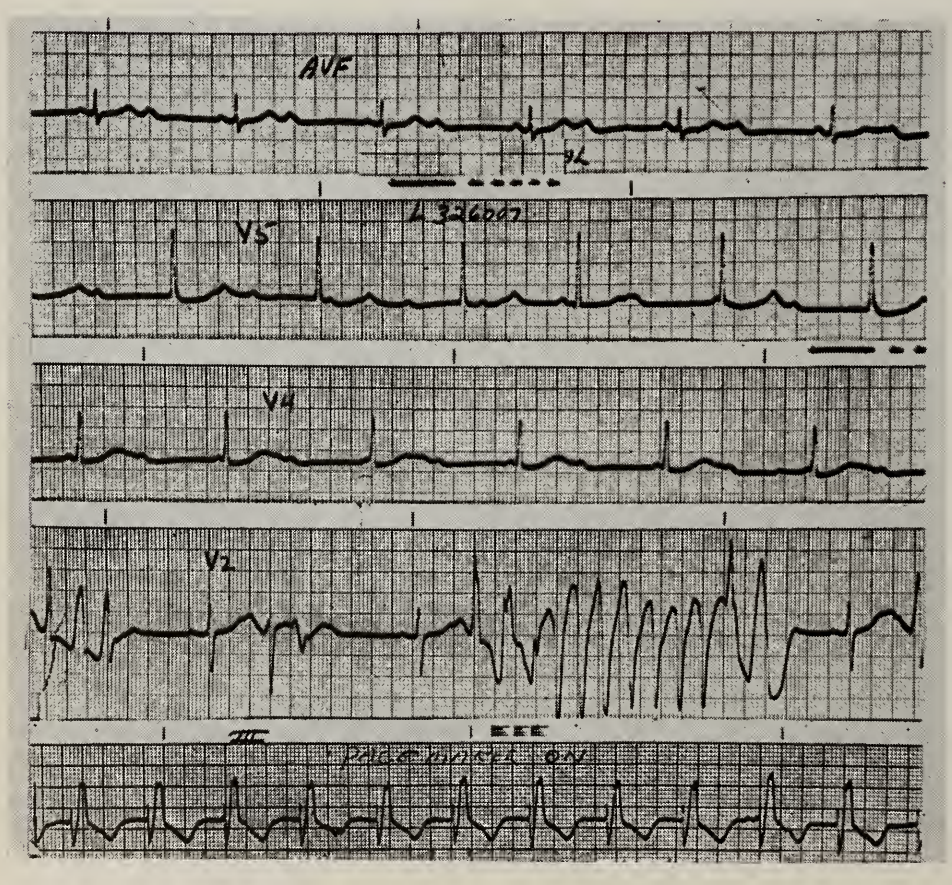


FIGURE 1
STRIP 1 - shows 2:1 A-V block. Strip 2 - complete A-V dissociation with one conducted impulse (fourth QRS). Strip 3 - complete A-V dissociation. Strip 4 - runs of ventricular arrhythmia. Strip 5 - heart being paced by an internal pacemaker anchored in the outflow tract of the right ventricle.

cating arrhythmia or standstill, have cerebral symptoms. A relative indication is a well documented history of severe Stokes-Adams seizure in the absence of acute myocardial infarction.

In considering any patient for an implantable pacemaker one must take into account (1) that experience with pacemakers is relatively limited (2) that in about 30-35 % of the cases the pacemakers fail for purely mechanical reasons and secondary procedures are necessary (Figure 2) (3) that fibrosis about the implanted electrode may act as an insulator causing a gradual increase of threshold of stimulation and perhaps finally preventing excitation of the ventricles (Figure 3) and (4) that resumption of normal sinus rhythm results in competition between the artificial pacemaker and normal cardiac mechanism for the control of the heart (Figure 4). Admittedly the latter is an unpreventable sequence of events because the block in Stokes-Adams is often transient and recurrent in nature. With the appearance of normal rhythm, however, the impulse may fall in the vulnerable phase of the heart and result in repetitive ventricular excitation. This is a rare but serious complication.

With the inevitable improvement in instrumentation it is likely that all patients with Stokes-Adams disease or even patients without symptoms, but with complete A-V block, will be treated with artificial pacemakers. It behooves us to remember however that as matters stand now, secondary procedures are necessary in about 30-35% of cases; that our experience with this form of therapy is very short—on an average, less than 36 months—and that 20-25% of patients with *Stokes-Adams symptoms refractory to drug therapy* and treated with artificial pacemakers died in less than 30 months. In view of these complications,

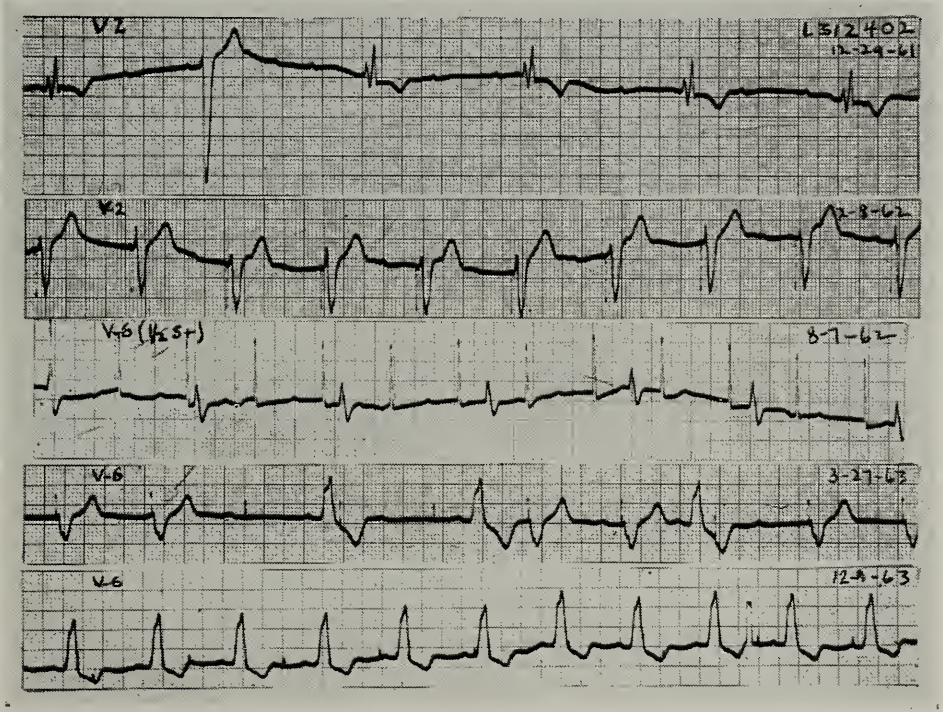


FIGURE 2

THIS IS A composite of tracings obtained on different dates and demonstrates the transient nature of block in Stokes-Adams disease, as well as some of the mechanical problems of internal pacemakers. Dec. 29, 1961 — A-V dissociation with the second QRS being conducted. Feb. 8, 1962 — the heart is being paced by an implanted electrical pacemaker. The impulses are registered as sharp lines preceeding the QRS complexes. Aug. 7, 1962 — the pacemaker fails to stimulate the ventricles with the QRS complexes appearing at a rate of 42 beats per minute and the artificial impulses at a rate of 86 per minute. March 27, 1963 — the pacemaker has been replaced some time previously but now shows a fluctuation of intensity of the impulse and periodic failure to elicit a ventricular response. The first two mechanical impulses elicit a ventricular response. The third one is of lower amplitude and fails to stimulate the ventricles. The subsequent QRS is initiated by a normal S-A impulse. The next mechanical impulse falls during an absolute refractory period and the heart fails to respond. The fifth mechanical impulse is again of diminished intensity and fails to arouse the heart, the subsequent QRS being sinus in origin. All subsequent mechanical impulses except for the eighth one, which falls during the absolute refractory period of a normal beat, elicit a ventricular response. Dec. 1, 1963 — normal sinus rhythm and ineffectual artificial impulses of small amplitude are seen.

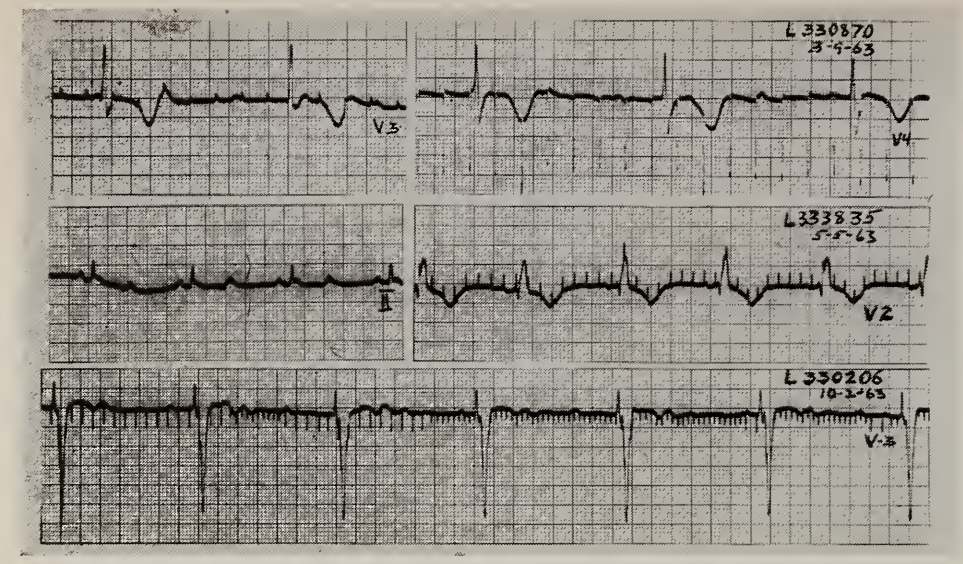


FIGURE 3
THESE ARE EXAMPLES of "run-away" pacemakers. The discharge rate is rapid, but in none does the heart respond to the artificial stimuli. In case 330870, 333835 and 330206 the rates are approximately 230 to 500 and from 540 to 900 respectively.

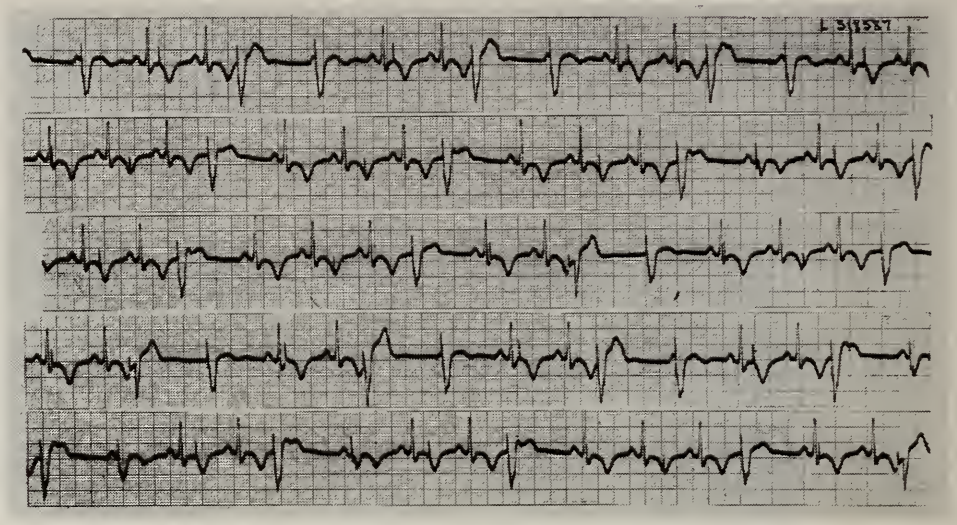


FIGURE 4
THIS IS AN example of reappearance of a normal sinus rhythm following implantation of pacemaker with a resultant pacemaker-induced "parasystole." The S-A node and the pacemaker compete for the control of the heart. Whenever the mechanical impulse falls outside the refractory period of the "normal" QRS it elicits a ventricular response. Although the impulse falls in various parts of the T wave, repetitive discharge did not appear.

the clearcut criteria to be used in selection of patients for treatment with artificial pacemakers, as outlined above and accepted by most, should be adhered to rigidly.

ECG Mechanisms of Stokes-Adams Attacks

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STOKES-ADAMS SYNCOPE occurs when cerebral blood flow is compromised due to an insufficient cardiac output. This reduction in cardiac output is the result of one of several cardiac mechanisms that can be deduced from ECG records. Traditionally this syndrome has been associated with the presence of complete atrio-ventricular block. Syncope associated with reduced cardiac output in the presence of complete A-V block is more correctly termed Stokes-Adams disease. Stokes-Adams syndrome can be applied to other cardiac mechanisms that result in a reduction in cerebral flow with subsequent symptomatology.

There are considerable variations in the manifestations of reduced cerebral blood flow and each individual reacts differently. In general however, symptoms will be produced in the patient who is deprived of adequate cerebral flow for as brief a period as three seconds. These symptoms may be described by the individual as a sensation of giddiness, lightheadedness, dizziness or other terms. If cerebral blood flow deprivation lasts as long as six seconds then loss of consciousness may occur. If blood flow is restricted for 12-18 seconds, most individuals will have convulsive seizures.

The purpose of this paper is to show the various ECG mechanisms associated with Stokes-Adams disease as well as to illustrate some of the arrhythmias that may give rise to cardiac-induced syncope.

Complete Heart Block

Complete atrio-ventricular block is the underlying condition associated with the occurrence of Stokes-Adams disease. Figure 1 illustrates some of the characteristics of complete A-V block. Strip A is a classic example of complete A-V block. The readily evident P waves are not associated with a QRS response. A condition of dissociation exists between the atria as manifested by P waves and the ventricles as manifested by QRS. In this illustration the atrial rate is about 100 while the ventricular response is 47. It should be further noted that the T wave of the QRS is often distorted by the superimposed P wave of atrial activation. The bizarre and broadened QRS suggests that the ventricles are under control of a pacemaker from an idioventricular rather than an atrioventricular node.

Clinically there is a high incidence of complete A-V block in association with diaphragmatic or posterior wall myocardial infarction. Strip B shows such an example. There is a small Q wave seen and the marked S-T segment elevation depicts a typical injury current pattern. The atrial activity is dissociated from the activity of the ventricles since P waves are seen with a rate of 75 while QRS response is about 35 beats per minute.

Since atria and ventricles are dissociated in complete A-V block, it is possible that the atria may demonstrate an arrhythmia of its own. Strip C shows such an example. The atria in this case are fibrillating, manifested by the coarse undulating base line in the tracing. The ventricular response is quite

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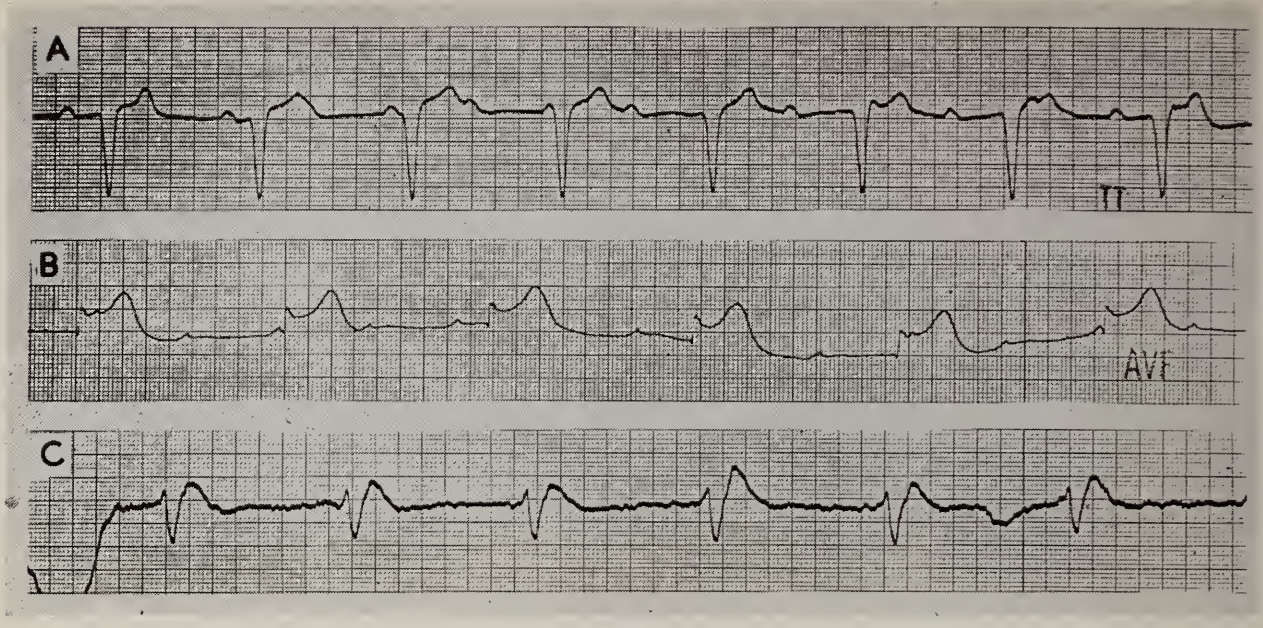


FIGURE 1
EXAMPLES of complete atrio-ventricular block. See text for details.

regular at a rate of about 38 beats per minute. The regularity of the ventricular response as well as the bizarre configuration of the QRS shows that complete A-V block exists and that the ventricles are not responding to atrial stimulation.

Mechanisms of Stokes-Adams Disease

There are three ventricular mechanisms that may occur in the presence of complete heart block, causing decreased cardiac output with subsequent reduced cerebral flow. They are: (1) very slow ventricular rate (2) ventricular standstill and (3) paroxysmal ventricular tachycardia. Figure 2 illustrates the mechanisms involved. Strip A shows a record that has few ventricular responses. In this subject the ventricular rate is only 20 beats per minute. It is easy to understand that in some individuals a rate this slow would be ineffective to maintain adequate cerebral blood flow. It is interesting to note that the atrial rate is slightly greater than 100 beats per minute so that a sinus tachycardia co-exists with this extremely slow ventricular rate.

Strip B initially shows two ventricular responses. The second beat is followed by a long pause during which P wave activity can be noted at a rate of 100 beats per minute. The pause, during which there is no ventricular response, lasts for 7.5 seconds and is terminated by three beats of probable

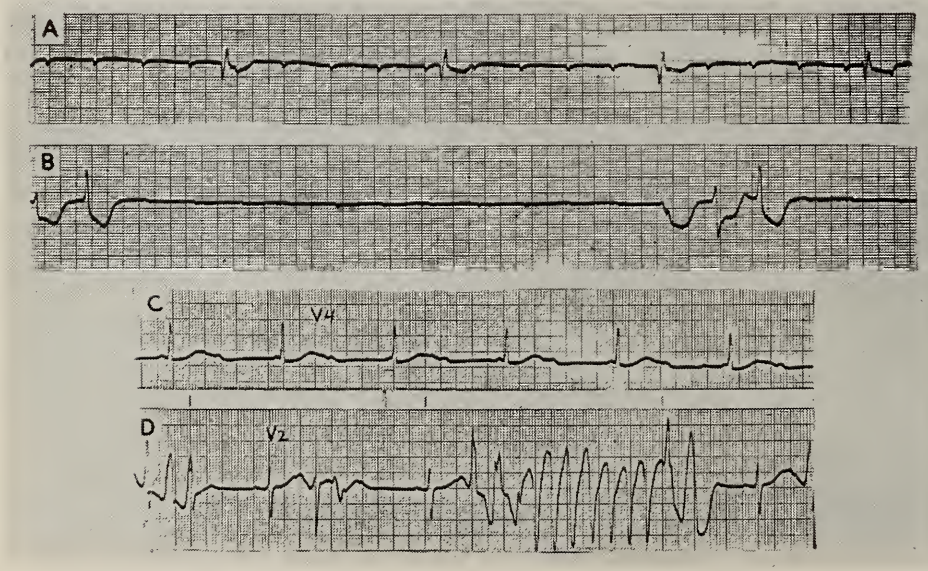


FIGURE 2
THE TYPES of mechanisms involved in Stokes-Adams disease. See text for details.

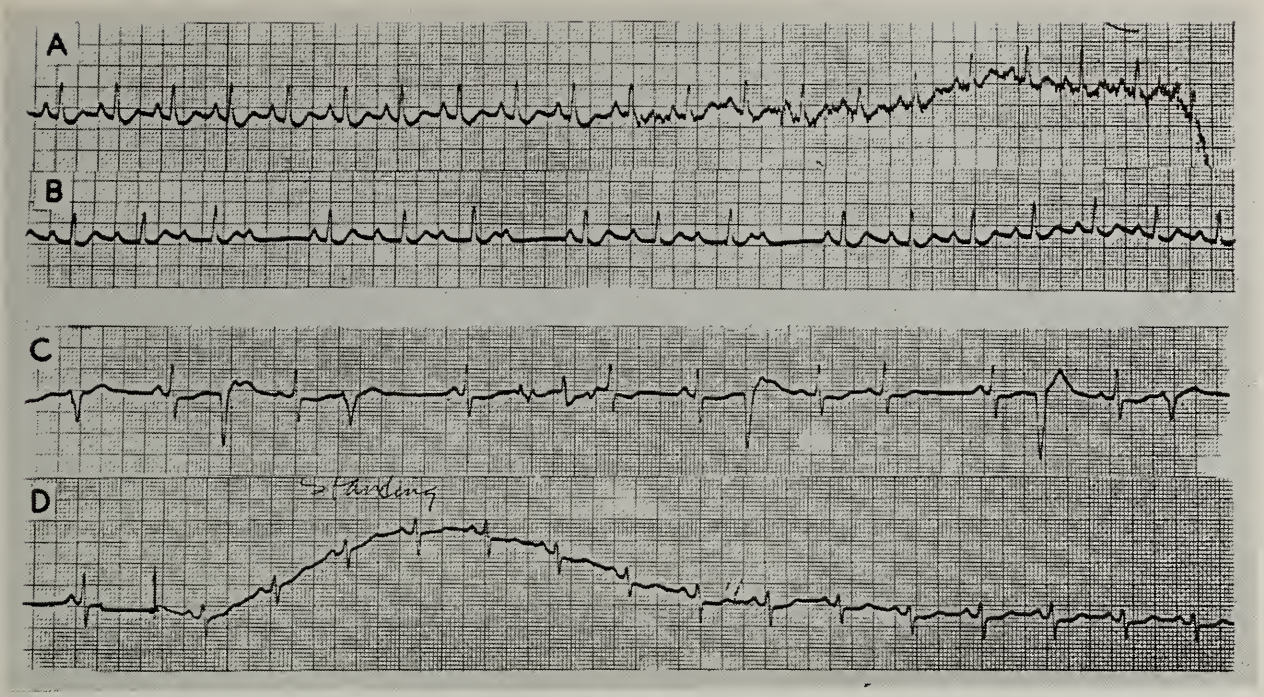


FIGURE 3
THIS DEMONSTRATES ARRHYTHMIAS associated with change in posture. See text for details.

ventricular origin. It is obvious that most subjects would have cerebral symptoms following such a prolonged period without ventricular response.

Strips C and D are both taken from the same patient on the same day. Strip C illustrates clearly that complete A-V block exists. The atria have a rate of 86 while the ventricular rate is 42 beats per minute. In strip D, in the middle of the record, there is a three second burst of ventricular tachycardia. The rate is quite rapid and the pattern chaotic. During episodes such as this there may be drastic reduction in cardiac output resulting in profound cerebral symptoms.

In cases of Stokes-Adams disease, it is likely that episodes of paroxysmal tachycardia are as frequently responsible for syncope as are episodes of ventricular standstill.

It should be re-emphasized that each of these three mechanisms occurred in the presence of complete A-V block. This concept becomes important when considering the treatment of Stokes-Adams attacks. For example, if complete A-V block is not present then the insertion of an electronic ventricular pacemaker will not provide a solution to the problem.

Postural Changes

There is an interesting group of subjects who show dizziness, unsteadiness or even syncope on changing posture. These people generally have a sinus rhythm and only on the change of posture is there a basic alteration in rhythm that is associated with Stokes-Adams type episodes.

Figure 3 is illustrative of types of mechanisms that can occur. Strip A and B are from the same patient. In strip A, the record is made as the subject changes from standing to lying down. The artifact in the baseline at the end of the record is secondary to this movement. Strip B taken only seconds later shows the onset of 2° A-V block with a Wenckebach phenomenon. While this particular subject did not have syncope, it clearly demonstrates that an advanced type of A-V block can occur with a change in posture as the stimulus. If a complete A-V block occurs in this circumstance then the possibility of Stokes-Adams attacks becomes apparent.

Strip C and D are from the same subject and are taken consecutively. Strip C shows a record made while the subject was lying down. Multifocal ventricular premature beats are seen throughout the tracing. It is in this milieu that a rapid ectopic ventri-

cular rhythm might occur with subsequent reduction in cerebral blood flow. Strip D shows that when the patient stands this chaotic pattern immediately reverts to a normal sinus rhythm.

Such cases are not common, but they must be kept in mind when analyzing the ECG mechanisms of Stokes-Adams attacks.

Syncope due to Other Cardiac Mechanisms

While our definition confined the occurrence of Stokes-Adams disease to the presence of complete heart block, it is important to recognize that syncope can occur due to other cardiac mechanisms. Generally speaking there are three mechanisms involved that lead to reduced cerebral flow: failure of sino-atrial node to propagate an impulse, sensitive carotid sinus reflex and rapid paroxysmal ectopic rhythms.

If for any reason there is a failure of impulse propagation within the S-A node, then there will be no ventricular response for a variable period of time. The usual course of events is for the A-V node or the ventricle to escape and assume at least temporary control of the heart thereby maintaining cardiac output. In certain individuals however, there may be a considerable pause between the time of failure of S-A node and the appearance of a secondary pacemaker.

Strip A in Figure 4 shows such a mechanism. The first two beats are separated by a pause that approaches three seconds. In a susceptible individual, symptoms might occur with such a pause. Basically, this tracing shows sinus arrhythmia with long intervals that appear to be a sinus arrest. In this record there is no evidence of an escape mechanism.

The mechanism of a sensitive carotid sinus is illustrated in strip B of Figure 4. In this case left carotid massage has resulted in ventricular asystole of four and one-half seconds. There is evidence of atrial activation as manifested by the four P waves seen during the pause. The atrial rate has slowed, however, from 75 beats per minute to 52 beats after carotid stimulation. This carotid stimulation has had a pronounced effect on the A-V junction, producing a transient block at the A-V junction. Such standstills are often terminated by the same escape mechanisms previously described. In this particular record it is likely that the first two beats following the ventricular asystole are A-V nodal escape beats. This is suggested by the fact that while their contour is the same as the conducted beats, the P-R intervals are much longer than the normal P-R interval and they are not equal to each other. The last two beats in the record are normally conducted beats originating in the S-A node.

Ectopic paroxysmal arrhythmias are capable of producing syncope. The pathophysiology involved is reduction in cardiac output secondary to the rapid ineffective rhythm. These paroxysmal tachycardias may occur from foci in the atrium, A-V node or ventricle. Figure 5 illustrates some such tachycardias.

Strip A shows a paroxysmal atrial tachycardia. The first four beats in the record are probably normally conducted beats in the presence of some sinus arrhythmia. The fifth beat is obviously premature and the P wave is buried in the preceding T wave. A rapid run of beats with normal QRS complexes and preceded by P waves follows the first premature beat. The rate is about 170 beats per minute. In susceptible individuals this might be sufficient to drastically reduce cardiac output and impair cerebral flow.

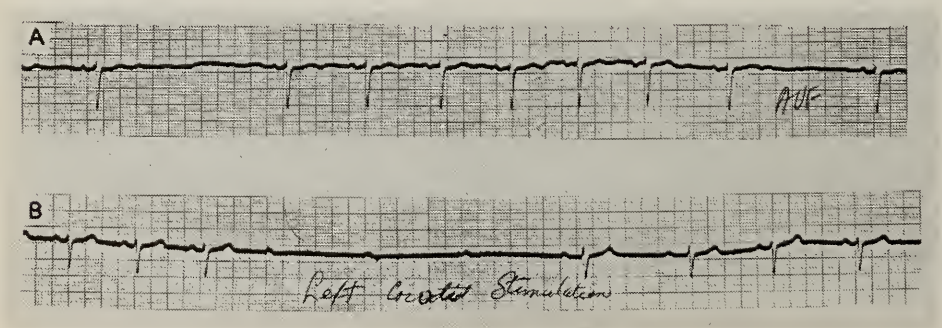


FIGURE 4
TWO MECHANISMS that can be involved in Stokes-Adams attacks without the presence of complete A-V block. See text for details.

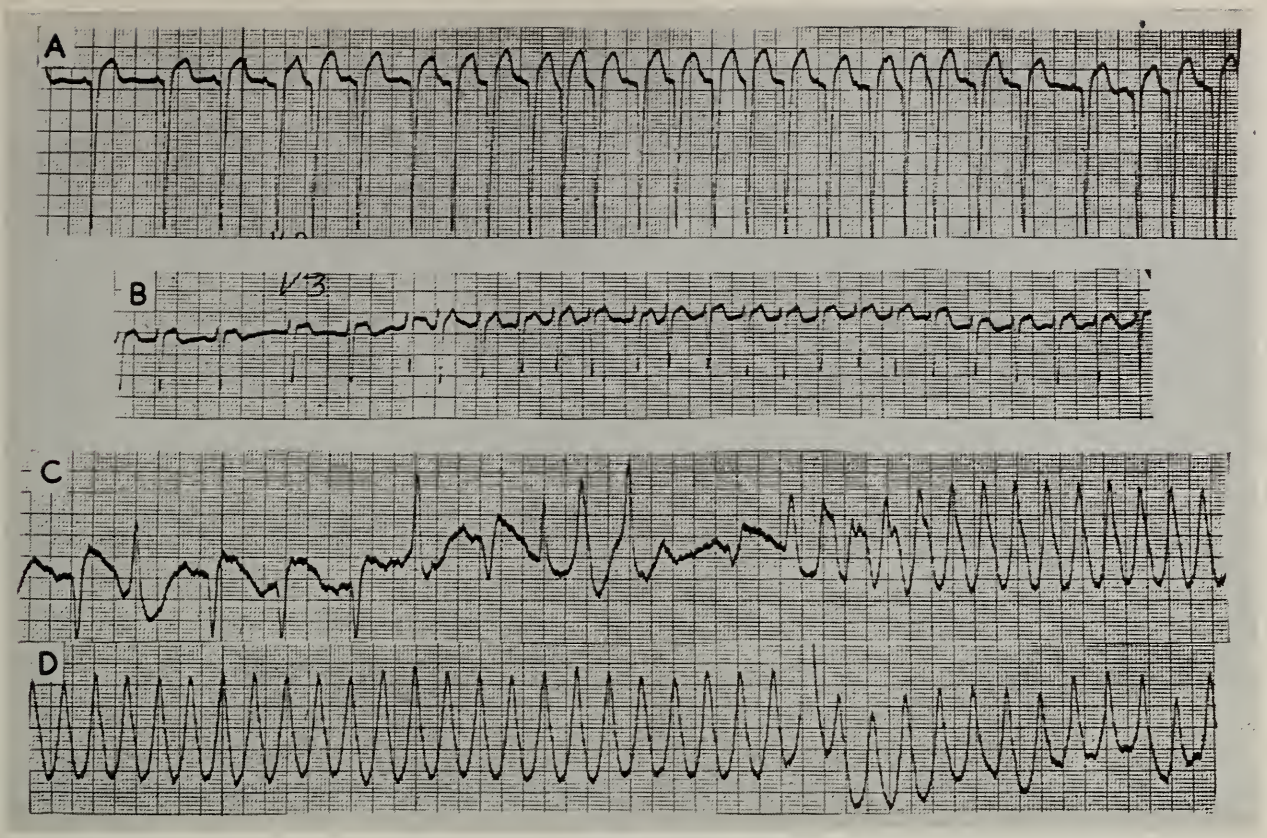


FIGURE 5
THREE PAROXYSMAL ectopic rhythms are depicted. These can be associated with Stokes-Adams attacks. See text for details.

Strip B in Figure 5 shows an episode of paroxysmal atrial tachycardia. Beats three-six are normally conducted beats preceded by obvious P waves. There is also a notched T wave which does not represent a superimposed P wave. The seventh QRS comes early and is followed by a long run of normally continued QRS complexes with varying R-R intervals. These beats are not preceded by P waves. This represents paroxysmal atrial tachycardia with a ventricular response of about 175 beats per minute. A rate and rhythm such as this represents an inefficient cardiac mechanism.

Strip C and D are continuous. The first and third-fifth beats are the normal beats for this individual. Interspersed in the record in strip C are numerous bizarre beats which represent ventricular premature systoles. At the end of strip C and continuing throughout strip D is a tachycardia manifested by a rate of 205 beats per minute with bizarre and broadened QRS complexes. This is illustrative of a paroxysmal ventricular tachycardia. This rhythm would be associated with a marked fall in cardiac output and consequently a compromise of cerebral blood flow.

It is important to again point out that the mechanisms illustrated in Figures 4 and 5 would not respond satisfactorily to the insertion of an electronic ventricular pacemaker. This is one of the primary reasons why concepts about the ECG mechanisms of Stokes-Adams disease and syncope become important. Not all patients who suffer Stokes-Adams attacks are candidates for insertion of a pacemaker.

Summary

The concepts of Stokes-Adams disease in association with complete A-V block are discussed.

It is important to distinguish Stokes-Adams disease from syncope due to other cardiac mechanisms.

Illustrative examples of the ECG mechanisms of Stokes-Adams disease as well as certain other cardiac mechanisms are presented.

Hemodynamic Alterations of Complete Heart Block

A Review

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Indianapolis

THE MAJOR PROBLEM encountered in complete heart block is Stokes-Adams syncope. These attacks, the result of cerebral ischemia due to an abrupt fall in cardiac output, may vary in severity from transient dizziness to complete loss of consciousness with or without convulsions.[1] Complete cardiac standstill, ventricular asystole with continuing atrial activity, ventricular fibrillation, and ventricular tachycardia or flutter are the cardiac mechanisms which have been implicated.[2] In a review of complete heart block in 251 patients, Penton et al.[3] documented a 61% incidence of Stokes-Adams syncope. In this series complete heart block due to digitalis intoxication did not result in syncope.

Coronary artery disease is the most common cause of complete heart block.[3] Hypertensive cardiovascular disease, rheumatic heart disease and digitalis intoxication are also relatively frequent causes.[3] Other entities which have been mentioned are acute rheumatic carditis,[4] congenital heart block,[5-7] diphtheritic carditis, syphilitic aortitis and calcification of the aortic or mitral valve.

The development of artificial cardiac pacemakers has aroused the interest of both clinician and physiologist. This device provides a means of obtaining hemodynamic data when the heart rate can be precisely controlled. An understanding of the hemodynamic consequences of complete heart block and the alterations in cardiac function produced by artificial pacemakers are of primary importance in applying this new therapeutic tool.

Stroke Volume and Cardiac Output

One of the basic questions that has been elucidated through the use of the artificial cardiac pacemaker is the relative roles that stroke volume and heart rate play in the control of cardiac output.

Rushmer[8] has demonstrated that during exercise the average subject has an increased heart rate and A-V 0_2 difference without significant change in stroke volume. Stroke volume increase accounts for the rise in cardiac output without an increased heart rate that is often seen in trained athletes. Wang et al.,[9] using a series of graded exercise in untrained dogs, observed that at maximal exercise the cardiac output increased by an average of 2.4 times the resting output while the stroke volume increased only 5 to 19%. The heart rate increased from 144 to 294 beats per minute during these studies. These investigators concluded that the increased cardiac output in untrained exercising dogs is a direct function of heart rate.

Warner and Toronto,[10] in contrast to the above, demonstrated in dogs with complete heart block whose rates were controlled with an artificial pacemaker, that the

*From the Krannert Heart Research Institute, Marion County General Hospital, the Department of Medicine and Heart Research Center, Indiana University School of Medicine, Indianapolis. Supported by the Herman C. Krannert Fund, the Indiana Heart Association, Indiana State Board of Health and (in part) by the U.S. Public Health Service Training Grant 5363 and (in part) with facilities provided by Cardiovascular Clinical Research Center Grant H-6308 from the National Heart Institute, National Institutes of Health, U.S. Public Health Service.

Dr. Mullican is a trainee of the National Heart Institute.

cardiac output is independent of heart rate at rest and with mild exercise. These two studies show that cardiac output can be increased by either an increase in heart rate or an increase in stroke volume but that a change in heart rate is the usual means of attaining this end.

With experimentally induced complete heart block in dogs there is an immediate fall in cardiac output to about one half of the pre-block output. Within 48 hours the cardiac output returns toward normal values due to increasing stroke volume and by 10-18 days the cardiac output is 80% of pre-block values.[11,12] At rates below 90 beats per minute, stroke volume is maximal and cardiac output is reduced. With maximal stroke volume, cardiac output becomes a direct function of heart rate. Starzl et al. have noted that stroke volume is maximal at the rate of 90 beats per minute or below in dogs and have therefore expressed this relationship:

$$\text{Cardiac output} = \frac{\text{Block rate}}{90} \times \text{control cardiac output.}^{11,12}$$

In the mid-range of heart rate (90-150 beats per minute) cardiac output remains constant but as the rate increases stroke volume decreases.[13,14] At higher rates the stroke volume continues to decrease and the cardiac output falls due to the diminished diastolic filling time. It has been demonstrated that diastolic ventricular size decreases with rapid heart rates.

Berglund[14] varied the filling pressure as well as heart rate and found that stroke volume was higher at slow rates than at faster rates for any given filling pressure.

Arterial pressure: After production of complete A-V block the systolic pressure quickly attains pre-block levels but there is a marked decrease in diastolic and mean blood pressure. Artifically increasing rate results in an increase of diastolic and mean pressure.[12] Miller et al. noted an elevation in mean blood pressure with increasing rates over the entire range studied (up to 240 beats per minute).[13] Wide pulse pressure is characteristic in laboratory animals with complete heart block.[12,13]

Right Auricular Pressure: Miller et al. noted an elevation of the right atrial and right ventricular end-diastolic pressures from 1-2 mm Hg to 8 mm Hg with lower and higher rates, due, presumably, to decreased clearing of the central reservoir.[13] Starzl et al. observed elevated right atrial pressures at slow rates,[12] and the development of congestive heart failure in dogs with chronic complete heart block and elevated right atrial pressures. Dogs with chronic heart block which maintained a compensated cardiac status either never had elevated right atrial pressure or, if initially elevated, it soon returned to normal.[15]

Effect on Myocardial 0_2 Consumption

There is no change in 0_2 consumption with production of complete heart block but an increased A-V 0_2 difference accompanies a decrease in cardiac output. Initially the A-V 0_2 difference is twice its pre-block level but gradually decreases as cardiac output returns toward normal.[12]

With the onset of complete heart block there is an immediate fall in myocardial 0_2 consumption and left ventricular work to about one-third of pre-block levels. Within 10-18 days both return to 80% of pre-block figures. With such a parallel relationship existing between ventricular work and myocardial 0_2 consumption little change in myocardial efficiency occurs.[12] Berglund has demonstrated that for any given work level the 0_2 consumption increases with heart rate, and that the heart is less efficient at higher rates.[14]

Immediately after production of complete A-V block there is a 50% reduction of coronary blood flow but within two days this figure increases to 75%. Coronary vascular resistance increases to 150% of pre-block level acutely but returns to normal in two days.[12]

Berglund observed that coronary vascular resistance at a rate of 230 beats per minute is less than half that at 60 beats per minute. The coronary flow is greater at these higher rates in spite of decreased time per minute for coronary perfusion. Since the relation between coronary blood flow and myocardial 0_2 consumption is the same for all rates studied, it is evident that myocardial 0_2 consumption is the major determinant of coronary flow.[14]

Complete Heart Block

It is important to distinguish between the congenital and the acquired forms of complete heart block because the heart rate is faster with the congenital form and can be increased with exercise or stress.[5-7] The ventricular rate is about 40 beats per minute and the stroke volume is increased to 150 to 200 cc. The cardiac output, intracardiac and pulmonic pressures are normal. The elevated arterial systolic pressure accompanied by normal diastolic pressure in these cases results in an increased pulse pressure due to increased stroke volume.[15,16]

In acquired complete A-V block there is a slow heart rate in the range of 20-40 beats per minute and generally an inability to increase heart rate in response to exercise or stress. These patients without clinical evidence of heart failure have been found to have elevated pressures in the right heart, increased systolic and pulse pressure in systemic circulation, increased pulmonary and systemic vascular resistance, increased stroke volume, reduced cardiac output and increased A-V 0_2 difference.[17,18] In one small series the renal plasma flow and glomerular filtration were also reduced.[18]

Muller and Bellet, in a report of complete heart block with intractable heart failure, observed an improvement in cardiac output when the heart rate was artificially accelerated to 50-65 beats per minute but noted that faster rates resulted in a sharp decline in cardiac output. In one case with a ventricular rate of 30 beats per minute the cardiac output was 2.7 1/minute. With artificial pacing at 50 beats per minute, the cardiac output increased to 3.2 1/minute. However, with a rate of 70 beats per minute the cardiac output fell to 2.5 1/minute.[19]

Johansson et al., recorded cardiac catheterization data in one case before and after artificial pacemaker insertion. With the ventricular rate at 27 beats per minute the cardiac output was 5.3 1/minute and stroke volume 230 cc at rest. These figures increased to 6.4 1/minute and 320 cc respectively with exercise. At 60 beats per minute the cardiac output was 4.7 1/minute and stroke volume 78 cc at rest, and with exercise the cardiac output increased to 9.5 1/minute accompanied by a marked increase in stroke volume to 158 cc per minute. It can be seen that there was a better response to exercise at this higher rate but little change in cardiac output occurred in the resting state by increased cardiac rate.[20]

Lasry et al., in one case, reported an increase in cardiac output paralleling an increase in heart rate over the range of 62-104 beats per minute. The cardiac output increased from 3.69 1/minute at 62 beats per minute to 4.09 1/minute at 104 beats per minute. Stroke volume decreased in a linear relationship with increased heart rate, ranging from 60 to 39 cc at the observed rates. Since cardiac output increased at the expense of stroke volume the inefficiency of this system is apparent.[21]

Abrams points out that in the presence of a fixed bradycardia and an inadequate myocardium lacking the ability to increase stroke volume, a state of low fixed cardiac output occurs. Under these circumstances an increased rate may result in a significantly increased cardiac output.[22] It must be noted, however, that even at moderately increased rates there may be little increase or even a decrease in cardiac output. Haupt et al. in a report of two cases noted that in one the cardiac index increased from 3.75 to 4.66 $1/m^2$/minute by increasing the rate from 58 to 84 beats per minute but at higher rates the cardiac index declined to 3.89 $1/m^2$/minute at 120 beats per minute. In the other case there was a progressive decrease in cardiac index from 4.78 to 3.22 $1/m^2$/minute with increased rate over the range of 38 to 119 beats per minute.[23]

To date there are studies of the hemodynamics during exercise in three patients with a pacemaker of varying frequency. In one case with exercise at a low fixed rate of 66 beats per minute the cardiac index increased from 2.7 to 4.0 $1/m^2$/minute as stroke volume increased from 74 to 111 cc. A further, though less striking, increase in cardiac index to 5.16 $1/m^2$/minute occurred when the same degree of exercise was performed at a rate of 114 beats per minute in spite of a decline in stroke volume to 86 cc.[23]

In both of the other patients there was a normal cardiac output within the range of 70-110 beats per minute while at slower

rates the cardiac output was diminished in spite of a greater stroke volume. During exercise at a heart rate of 50-70 beats per minute the cardiac output was increased because of a larger stroke volume, and quickening of the rate did little to improve the cardiac output. Systolic, diastolic and mean systemic pressures rose as heart rate was increased up to about 50 beats per minute with little change thereafter. At higher rates the pulse pressure and systolic pulmonary artery pressure decreased both at rest and during exercise. The mean right atrial pressure was normal but decreased with increasing heart rate.[24]

Summary

Complete heart block results in bradycardia, elevated right heart pressures, increased systolic and pulse pressure, increased pulmonary and systemic vascular resistance, increased stroke volume, reduced cardiac output and increased A-V 0_2 difference.

Observations of the effect of varying heart rates in both human and animal subjects with complete heart block have established that, in many cases, a moderate increase in heart rate results in improved cardiac function. With the rate slower or faster than the optimal rate there is a deterioration of cardiac performance. The hemodynamics of complete heart block and the effect of the artificial pacemaker on cardiovascular function are reviewed.

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Case report and review of the literature

The Treatment of Ventricular Fibrillation By External Cardiac Massage and Defibrillation

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FAITH HEALERS and television programs have been reporting saving of lives by laying-on-of-hands and by electrical machines for many years. It is somewhat sobering to realize that, with some revisions in technic, physicians are now successfully applying these procedures to ventricular fibrillation.

This has been brought about by the clinical application of external defibrillation by Zoll in 1956[1] and cardiac massage by Kouwenhoven in 1960.[2] Since 1956, 46 cases have been reported in detail in which external massage and defibrillation have been used to overcome ventricular fibrillation. A brief review of these cases has been made in order to find: (a) circumstances under which ventricular fibrillation has occurred and yet the patient survived (b) length of time the patient can survive with external massage (c) the number and strength of shocks tolerated by patients and (d) the ability of paramedical personnel to apply cardiac massage.

Case Report

The patient, a 72-year-old male, had been hospitalized twice in three years for "valvular heart disease" and symptoms of congestive failure (Figure 2). He had been experiencing left chest pain brought on by exercise and relieved by rest and nitroglycerin. On the morning of admission he had taken three nitroglycerin tablets prior to visiting a friend in the hospital. During this visitation he collapsed in his chair. Three physicians were nearby and reached him within 30 seconds. The patient was unconscious, blood pressure and pulse were unobtainable. He was placed on a hospital cart and external massage was begun within two minutes after collapse. An oral airway was inserted, and intermittent positive-pressure oxygen was administered by mask until the patient was able to ventilate himself.

An electrocardiogram revealed ventricular fibrillation (Figure 1a). The external defibrillator was applied 10 minutes after collapse. He was given three 350 volt shocks before the fibrillation ceased. During the next 30 minutes two more episodes of ventricular fibrillation occurred requiring four additional shocks of 350 volts. A total of 500 mg. of pronestyl was given intravenously over this period. The pacemaker was used on one occasion for brief arrest following defibrillation. (Serial electrocardiograms are shown in Figure 1, b-k). Vasopressors were required for the first two days. Mild amnesia persisted for three days.

After sinus rhythm had been established (Figure 3) a grade III/VI holosystolic murmur was heard at the apex with radiation to the left axilla. The chest x-ray revealed a markedly enlarged left ventricle. According to the patient's physician, these findings had been present for at least two years. The initial serum transaminase was 188 units. Serial ECG's showed no evolution of a myocardial infarction. The patient was transferred to another hospital 15 days after admission. He was in good health and at home six months following discharge.

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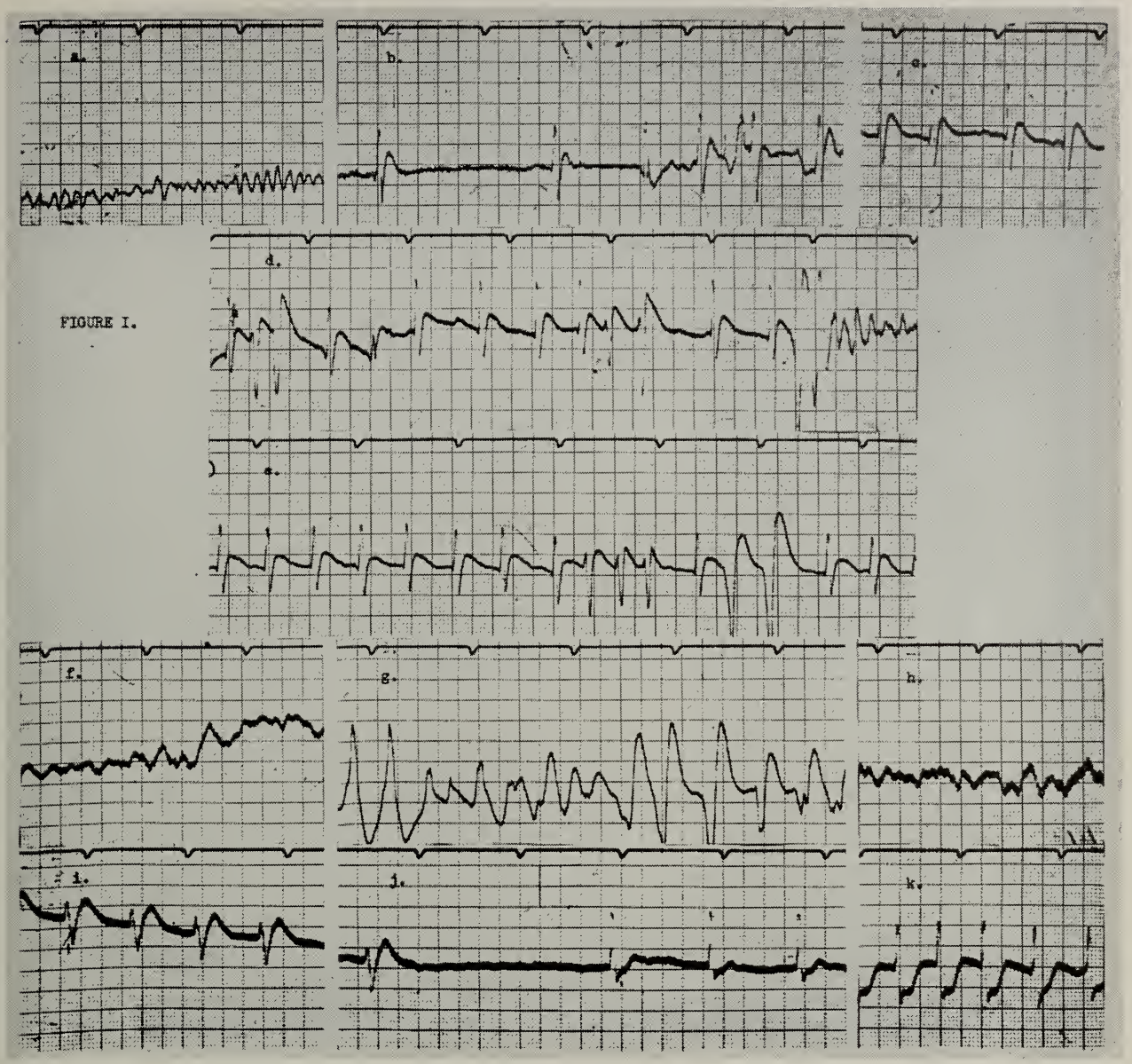


FIGURE I.

FIGURE 1

(a) FIRST EPISODE of ventricular fibrillation requiring three shocks for conversion. (b) Conducted atrial beats at slow rate followed by idioventricular rhythm with multiple premature ventricular complexes. (c) Continued idioventricular rhythm. (d) Premature ventricular complexes increasing. At the end of the strip, a premature complex falls on the T-wave initiating the second episode of ventricular fibrillation. (e) After the fourth shock, a nodal rhythm with many premature ventricular beats. (f) Third episode of ventricular fibrillation. (g) Continued ventricular fibrillation after fifth shock. (h) Continued ventricular fibrillation after sixth shock. (i) Nodal rhythm after seventh shock. (j) Nodal rhythm converting to slow atrial fibrillation. (k) Rapid atrial fibrillation.

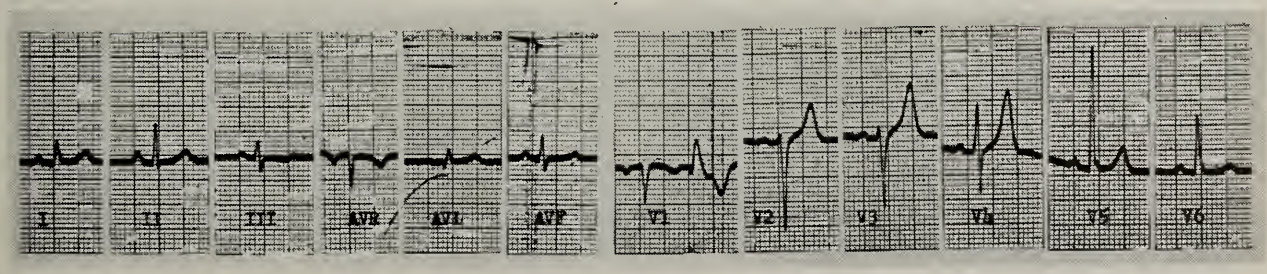


FIGURE 2

TAKEN ON August 1, 1959, about three years before hospitalization showing nonspecific ST-T wave changes compatible with ischemia and/or digitalis effect.

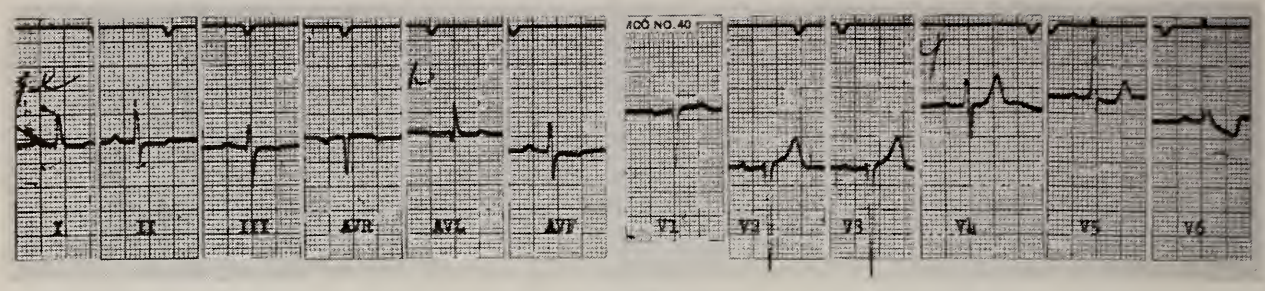


FIGURE 3
TAKEN TWO WEEKS after ventricular fibrillation showing sinus rhythm and non-diagnostic changes of minimal ST segment depression in leads, II, III, and V6 with T-wave inversion in V6.

Review of the Literature

Case reports listed in the following tables have been described in detail in the literature. There have been other reports on the use of external massage and defibrillation on large series of patients which were not detailed enough to include.[28-31] Also ventricular fibrillation occurring during convalescence from cardiac surgery has not been included.

Table 1 lists the cases associated with acute myocardial infarction. All of the episodes occurred after the patient had been admitted to the hospital and several while an ECG was being taken. Case 12 represents a prolonged period of massage (45 minutes) because defibrillation equipment could not be immediately obtained. Other cases show maintenance of adequate circulation for 14 to 30 minutes. The longest period before initiation of massage was in cases 9 and 14. Both of these were reported as "less than five minutes" and thus may have still fallen with in the critical "four-minute limit".[32] Nursing personnel began massage in cases 7 and 10. In case 1 both direct and alternating current were used; better, more apparent results were obtained using direct current.

The cases associated with cardiac catheterization are listed in Table 2. A high survival is expected since all of these cases were being monitored and defibrillator equipment was close at hand. Several authors[16,18,19] recorded direct arterial pressures during massage and showed these to be as adequate as those obtained during direct massage after thoracotomy.

Ventricular fibrillation associated with Stokes-Adams syndrome and/or complete heart block is listed in Table 3. There appeared to be no upper limit to the number of times a patient can be defibrillated and yet survive. The cases associated with drug toxicity are listed in Table 4. Quinidine was involved in three of the four cases reported. Eight cases could not be easily categorized and are thus listed under miscellaneous or unknown causes in Table 5.

Discussion

The technic of external massage and defibrillation has been well described elsewhere.[1,2,33] It should be re-emphasized, however, that maintenance of a functioning airway is as important as massage or defibrillation.

It is critical that cardiac massage be started immediately. The patients who survived are the fortunate ones whose episodes of ventricular fibrillation occurred by chance in a hospital where physicians and equipment were immediately available. Had our patient, reported here, had his attack just outside the hospital he probably would not have survived.

Any attempt to predict ventricular fibrillation is futile except in patients with the Stokes-Adams syndrome who have had their previous attacks due to ventricular fibrillation. The overall incidence of this arrhythmia in acute myocardial infarction, in cardiac catheterization, or from the use of quinidine precludes any attempt to predict its occurrence. It would not be unreasonable, however, to instruct nursing personnel in the recognition of clinical cardiac arrest and the proper technic of external massage. The feasibility of this has already been demonstrated. Also, it has been suggested that patients in whom ventricular

CASES ASSOCIATED WITH ACUTE MYOCARDIAL INFARCTION

Case	Age	Sex	Location Infarction	Episodes Ventricular Fibrillation	Shocks	Voltage Used	Delay Before Massage	Delay Before Shock	Complications, Results, and Follow-up	Author
1.	40	M	Not reported	Repeated	Repeated	350-750	Immed.	30 min.	Direct current 120 watt sec. Direct current more effective. Expired 17 hrs. later.	Stanzler[3]
2.	45	F	Posterior	1	3	350	Immed.	6 min.	Well six months later.	Nast[4]
3.	45	M	Anterior	2	2	N.R.	Immed.	20 min.	Recovered. Follow-up not reported.	Kouwenhoven[2]
4.	45	M	Anteroseptal	2	3	480-880	1 min.	N.R.	Well 32 days later.	Thal[5]
5.	50	F	Not reported	1	3	350-550	secs.	25 min.	Well eight months later.	Keevil[6]
6.	52	M	Anteroseptal	1	4	440-880	4 min.	N.R.	Amnesia 36 hrs. Well one month later.	Thal[5]
7.	52	M	Not reported	1	1	450	N.R.	19 min.	Nurse began massage. Converted to sinus rhythm. Expired.	Keevil[6]
8.	56	M	Posterior	1	4	350-450	3 min.	30 min.	Four rib fractures. Well six weeks later.	Colmers[7]
9.	56	M	Not reported	1	3		5 min.	15 min.	In Germany, 1500 v., 2 amp. direct current. Previous anterior infarction. Expired 21 hrs. after defibrillation. Post-mortem revealed fresh infarction.	Friese[8]
10.	59	M	Anteroseptal	2	2	350	Immed.	N.R.	Nurse began massage. Well three weeks later.	Lakra[9]
11.	60	M	Anteroseptal	1	1	250	30 sec.	1½ min.	Well one month later.	Shohet[10]
12.	61	M	Not reported	4	7	250-550	Immed.	45 min.	Transverse myelitis 10 days later. Expired 49 days later. Post-mortem showed areas of old and recent myocardial necrosis.	Fuisz[11]

TABLE 1 (Continued on next page)

CASES ASSOCIATED WITH ACUTE MYOCARDIAL INFARCTION

Case	Age	Sex	Location Infarction	Episodes Ventricular Fibrillation	Shocks	Voltage Used	Delay Before Massage	Delay Before Shock	Complications, Results, and Follow-up	Author
13.	61	M	Inferior	1	1	N.R.	N.R.	15 min.	Pneumothorax and mediastinal emphysema. Well seven months later.	Moss[12]
14.	61	M	Posterior	2	6		5 min.	14 min.	In Germany, 1500 v., 2-4 amp. direct current. Expired eight days later. Bronchopneumonia.	Friese[8]
15.	62	F	Anterior	2	2	N.R.	3 min.	22 min.	Atelectasis RLL. Well 10 months later.	Moss[12]
16.	64	F	Not reported	1	1	360	N.R.	7 min.	Arrest after defibrillation.	Zoll[1]
17.	66	F	Anteroseptal	1	1	250	N.R.	N.R.	Converted to sinus rhythm. Oliguria and progressive failure. Expired 10 days later.	Lakra[9]
18.	67	M	Posterior	1	2	250-590	2 min.	14 min.	Converted. Cardiac arrest two days later.	Julian[13]
19.	69	M	Inferior	1	1	N.R.	½ min.	N.R.	Well six months later.	Moss[12]

TABLE 1 (Concluded)

CASES ASSOCIATED WITH CARDIAC CATHETERIZATION

Case	Age	Sex	Location Heart Lesion	Episodes Ventricular Fibrillation	Shocks	Voltage Used	Delay Before Massage	Delay Before Shock	Complications, Results, and Follow-up	Author
1.	10 d.	M	Transposition great vessels patent foramen ovale.	1	4	150	N.R.	20 min.	Expired one month later.	Sasahara[14]
2.	6 wk.	M	Severe mitral stenosis with marked pulmonary hypertension.	6	7	150	N.R.	secs.	Occurred while isolating saphenous vein. Emergency valvulotomy after catheterization resulted cardiac arrest.	Sasahara[14]
3.	2 mo.	F	Complete endocardial cushion defect; dextroposition of aorta; persistent lt. superior vena cava.	1	1	150	Immed.	2 min.	Defibrillation successful. Regurgitated, aspirated, expired three days later.	Ryan[15]
4.	3 mo.	F	Dextroversion heart; atrial and ventricular septal defects.	1	2	150	N.R.	1½ min.	Recovered and expired one month later.	Sasahara[14]
5.	17	F	Subaortic stenosis.	1	9	N.R.	Immed.	N.R.	Fibrillated 55 min. Well 16 days later.	Cohen[16]
6.	18	F	Tetralogy of Fallot; age six, lt. subclavian and pulmonary artery anastomosis; age 11, rt. sided anastomosis.	1	2	N.R.	N.R.	70 sec.	Well three days later.	Kouwenhoven[17]
7.	33	M	Aortic stenosis and insufficiency. Occurred with femoral catheter in place and infiltrating chest wall for cardiac puncture.	1	Repeatedly	250	N.R.	40 sec.	Unable to defibrillate externally. Thoracotomy and direct massage unsuccessful. Expired.	Nyboer[18]
8.	36	M	Angina pectoris with normal ECG. Catheterization for coronary angiogram	1	Repeatedly	150	Immed.	N.R.	Occurred after test dose contrast media. Unable to defibrillate externally. Thoracotomy and direct massage successful. Expired 16 hr. later another episode ventricular fibrillation.	Gurewich[19]

TABLE 2

CASES ASSOCIATED WITH STOKES-ADAMS SYNDROME AND/OR COMPLETE HEART BLOCK

Case	Age	Sex	Associated Conditions	Episodes Ventricular Fibrillation	Shocks	Voltage Used	Delay Before Massage	Delay Before Shock	Complications, Results, and Follow-up	Author
1.	57	F	Varying degrees A-V block	17	9	250-450	N.R.	1 min.	Discharged after 23 seizure-free days. Expired at home four days later.	Zoll[20]
2.	67	M	Dec. 4, 1955	1	5	180-300	N.R.	2.7 min.	Discharged nine days after last episode.	Zoll[1]
			Dec. 6, 1955	1	3	300-312	N.R.	2.1 min.		
			Dec. 11, 1955	1	2	300-360	N.R.	2.2 min.		
	70	M	Jan. 1958 (same case)	Repeated	Repeated	250-450	N.R.	<3 min.	Episodes ceased six weeks. Expired at home.	Zoll[20]
3.	68	M	Complete heart block	48	31	150-450	N.R.	N.R.	Seizures two week period. Expired at home one month later.	Zoll[20]
4.	72	M	Complete heart block	10	10	N.R.	N.R.	N.R.	Seizures four day period. Expired after last defibrillation.	Kouwenhoven[17]
5.	72	M	Complete heart block treated with pacemaker causing ventricular fibrillation.	2	3	370	N.R.	N.R.	Unable to defibrillate second episode.	Effort[21]
6.	78	F	Hypertension, angina, and 2:1 A-V block	21	21	150	N.R.	N.R.	Seizures seven day period. Expired hemorrhages anticoagulation three days later.	Zoll[20]
7.	84	F	Complete heart block	93	21	250			72 episodes defibrillated spontaneously. Well four months later.	Sacolick[22]

TABLE 3

CASES ASSOCIATED WITH DRUG TOXICITY

Case	Age	Sex	Drug, Dosages and Time Intervals	Episodes Ventricular Fibrillation	Shocks	Voltage Used	Delay Before Massage	Delay Before Shock	Complications, Results, and Follow-up	Author
1.	28	F	Rheumatic heart disease with mitral and tricuspid incompetency, atrial fibrillation two weeks post op. mitral repair with baffle, received 9 gr. quinidine q. two hours for five doses. Episode began nine hours after last dose.	2	N.R.	N.R.	N.R.	N.R.	Also had 10 episodes flutter and two flutter fibrillation. All converted externally. Well six months later.	Rainier[23]
2.	31	F	Rheumatic heart disease with mitral insufficiency, atrial fibrillation 19 months post annuloplasty, received 9 gr. quinidine q. two hours for 5 doses. Episodes began four hours after last dose.	15	N.R.	N.R.	N.R.	N.R.	Also had 50 episodes flutter and 25 flutter fibrillation. Cardiac arrest 28 hrs. after first attack.	Rainier[23]
3.	63	M	Admitted with "nausea and vomiting from digitoxin overdosage." Dosage not reported.	2	1	250	N.R.	33 sec.	Arrest after five and one-half min. idioventricular rhythm.	Zoll[1]
4.	74	F	Developed atrial fibrillation while taking thyroid extract. Received quinidine 0.4, 0.6, 0.8 gm. at two hour intervals. Sinus rhythm six hours after last dose. Ventricular fibrillation twenty hours after last dose.	1	1	N.R.	N.R.	N.R.	Later learned that enteric coated quinidine was given. Uneventful recovery. Follow-up not reported.	Logue[24]

TABLE 4

CASES ASSOCIATED WITH MISCELLANEOUS OR UNCERTAIN CAUSES

Case	Age	Sex	Associated Conditions	Episodes Ventricular Fibrillation	Shocks	Voltage Used	Delay Before Massage	Delay Before Shock	Complications, Results, and Follow-up	Author
1.	40	M	One month after acute posterior myocardial infarction.	1	1	N.R.	Immed.	20 min.	Shocked three more times for ventricular tachycardia. Serial ECG's not diagnostic for infarction. Well six months later.	Parmley[25]
2.	59	M	Arteriosclerotic heart disease with ventricular tachycardia. Given shock 350 v. and developed ventricular fibrillation.	1	1	350	Not done	Immed.	Discharged. Follow-up not reported.	Alexander[26]
3.	67	F	Severe renal disease, azotemia, anemia, hypertension, anasarca.	Repeated	59	150-450	N.R.	N.R.	Died six days after admission.	Zoll[20]
4.	69	M	Known coronary artery disease. Admitted after brief syncope.	1	1	450	Immed.	11 min.	Recovered. Well one year later.	Keevil[6]
5.	70	M	Known coronary artery disease. Admitted in shock after severe chest pain.	1	Repeated	N.R.	Immed.	10 min.	Unable to defibrillate. Post-mortem revealed no fresh infarction.	Keevil[6]
6.	73	F	Hypertension, angina, acute pulmonary edema, atrial fibrillation being digitalized.	1	5	150-450	N.R.	N.R.	ECG showed no evidence myocardial damage. Well six months later.	Zoll[20]
7.	73	M	Hypertension and acute lt. ventricular failure.	3	3	480	Immed.	1.7 min.	Discharged three weeks later. Normal sinus rhythm.	Zevon[27]
8.	78	M	Circulatory collapse for at least 15 min.	7	8	240-720	N.R.	1 min.	Cardiac arrest after last defibrillation.	Zoll[1]

TABLE 5

fibrillation might occur be placed on a constant cardiac monitor.[34] This would certainly add to the number of survivals from this arrhythmia. However, the expense of equipment and personnel would be immense.

Summary

Forty-six cases of ventricular fibrillation treated with external cardiac massage and external defibrillation from the literature are reviewed. One case reported here is added to the list. The critical importance of immediate recognition and treatment limits the successful cases to hospitalized patients.

Acknowledgment

The author wishes to express his appreciation to Drs. Pasquale Genovese and Sheldon Steiner for their help.

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From the Journal 50 Years Ago

. . . In the forearm and the leg with double bone support lies a fertile field for bone plates. To avoid growing together, which hinders rotation, to avoid shortening of one side or other or angular deformity, there is nothing like the plate. In the leg where the most important weight bearing bone, the tibia, is concerned, it should be granted every possible help looking toward its best correction and should be plated properly, sometimes with more than one plate in oblique or spiral fractures. The fibula is secondary, of course. It has been observed that the lower third of the tibia is unfavorable ground for bone plates. This is due possibly to the lack of easy covering of the area after operation by the scanty tissues above the ankle or perhaps by the injury to these tissues by the trauma of operation or fracture and extraordinary care should be taken in this region.

The ilium, scapula and clavicle lend themselves readily to plating, especially the first two. Failures with the clavicle are usually due to technical errors or too large a plate. Plating on the skull has not been done to my knowledge but it might be useful with thin plates curved to the right degree with short screws to hold in place large fragments. It is true, however, that a skull fracture which would cause such damage most often causes death and that our method of osteoplastic flap opening in craniotomies requires no holding measures to close the trap door flap. . . .

Kellogg Speed, M.D., "Selection of Cases for Internal Bone Splints", *JISMA,* February, 1914.

X-RAY CONFERENCE

Presented as a regular feature of *The Journal*, X-ray Conference is a series of short talks on procedure and radiologic diagnosis, edited by Erich K. Lang, M.D.

Pericardial Effusion

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A 27-YEAR-OLD white female was admitted to Methodist Hospital with a presumptive diagnosis of pericardial effusion. Pain and a pericardial friction rub were present. ECG changes suggested myocardial involvement. Dyspnea and orthopnea, tachycardia with a diastolic gallop rhythm, as well as venous distension and acute hepatic enlargement were noted in the physical examination. Viral studies had been attempted some four weeks after the onset of the illness. Neutralizing antibodies of the Coxsackie group "B", type 5, were present in a dilution of 1/128.

A chest roentgenogram demonstrated a classical water-bottle configuration of the heart shadow. The right and left cardiophrenic angle showed acute and sharp angles. Chest fluoroscopy revealed a definite decrease of cardiac pulsations. Kymography was not carried out. A carbon dioxide study was attempted for definitive diagnosis. The patient was placed in a left lateral decubitus position and 200 cc. of carbon dioxide introduced into the left antecubital vein. The carbon dioxide was allowed to gravitate into the superior vena cava and right atrium. Approximately 30 seconds after the introduction of the carbon dioxide, a single film was exposed. A sickle-shaped carbon dioxide shadow delineated the right atrium and demonstrated a space of soft tissue density of approximately 2½ cm. diameter above the right atrium. This corresponds to the pericardial space protruding above the right atrium in a lateral decubitus position. A definite diagnosis of pericardial effusion was thus established.

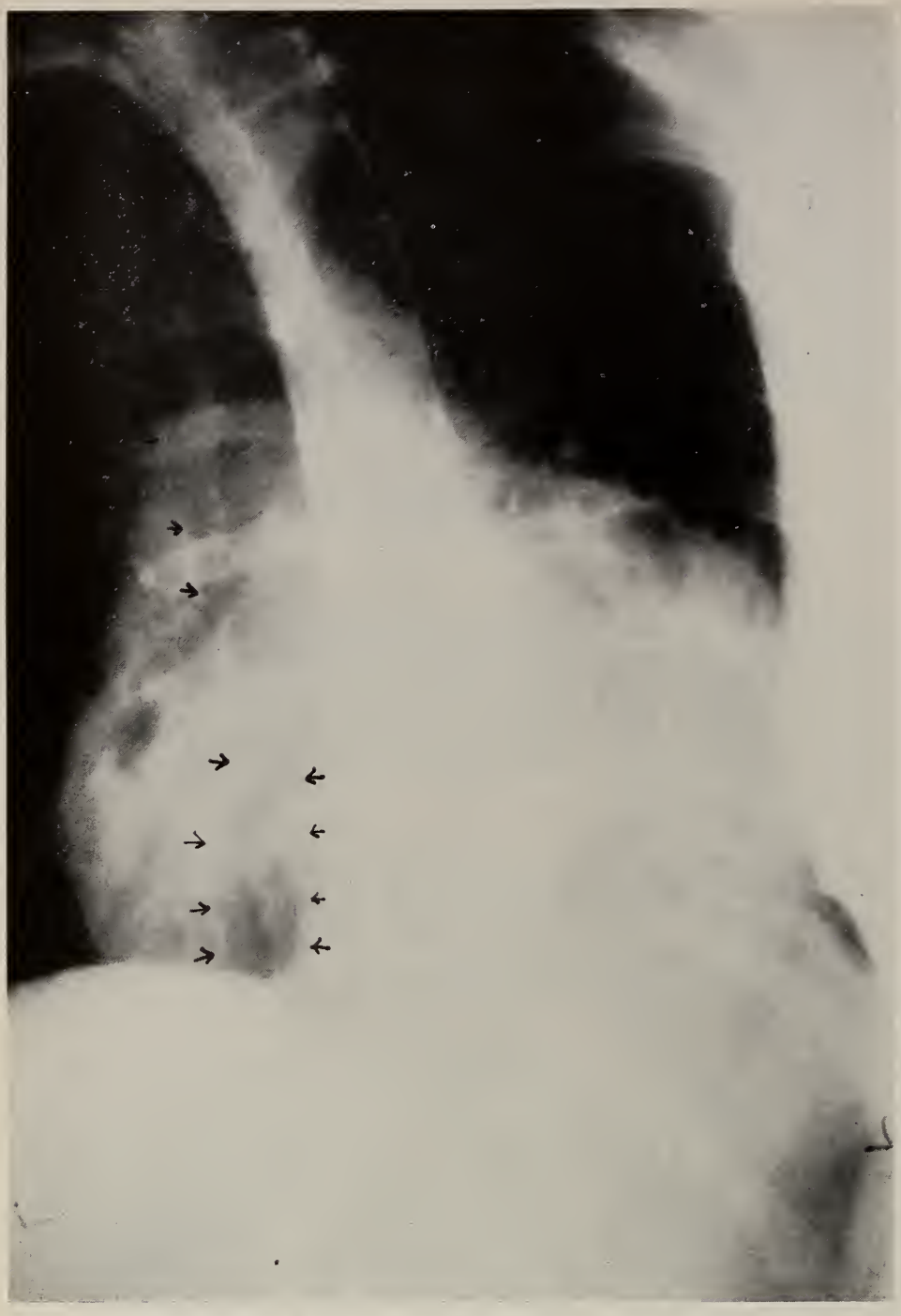
*Radiologist, Methodist Hospital.

Discussion

The diagnosis of pericardial effusion by physical examination, ECG, and roentgenographic examinations is, at best, difficult. Kymography offers a reliable tool but is not readily available. Angiocardiography with contrast medium filling of the ventricular components would, likewise, readily demonstrate the presence or absence of increased thickness of the pericardial space suggestive of a pericardial effusion. Tomography will occasionally demonstrate a fat pad in the myocardial sulcus, again allowing assessment of the thickness of the overlying pericardial space. The failure of concentration of RISA in the pericardial sac is used for the diagnosis of percardial effusions by scintiscanograms utilizing RISA injection. The simplest and most reliable method, however, remains the carbon dioxide study.

Method

Two-hundred cc. of carbon dioxide are injected into the left antecubital vein with the patient in a left lateral decubitus position. Thirty seconds are allowed to gravitate the carbon dioxide into the superior vena cava and right atrium. The events are recorded on a single film. The right atrial con-



A LATERAL DECUBITUS chest film demonstrates a sickle-shaped gas shadow in the right atrium and conglomeration of gas in the superior vena cava. A soft tissue shadow superior to the right atrium represents the thickness of the pericardial space and pericardium. This signifies a significant pericardial effusion.

tour is clearly delineated on this film and the thickness of overlying tissue allows an appropriate estimation of the pericardial space above the right atrium.

Following the completion of this study the patient was retained in the left lateral decubitus position for approximately 15 minutes. The entire amount of carbon dioxide is readily absorbed by the blood within four to five minutes. Air embolism will be avoided if this position is retained for at least 10 minutes.

It should be recognized, however, that although an increased thickness of the overlying pericardial space, as shown by the carbon dioxide study, establishes the definite diagnosis of a pericardial effusion or pericardial thickening the absence of this finding does not preclude the possibility of a localized pericardial effusion over other ventricular components. Pericardial effusions need not necessarily communicate throughout the pericardial space but may be loculated.

The relative ease and safety of this diagnostic procedure, plus the lack of complicated equipment needed to perform it is emphasized.

LABORATORY MEDICINE

This page reviews established or relatively new but reliable laboratory procedures for physicians in general. It is not designed for specialists and laboratory personnel who would desire more technical information.

Protein Immunoelectrophoresis

*WEI-PING LOH, M.D.**
Gary

PROTEIN IMMUNOELECTROPHORESIS is a new laboratory procedure combining the technics of immunodiffusion and electrophoresis. In immunodiffusion a precipitin band can be demonstrated in agar if an antigen and its specific antibody in the form of antiserum are allowed to react in the agar. In electrophoresis, protein components of different iso-electric points can be separated in an electrical field.

Method

A simple technic is to use agar in barbitone acetate buffer (pH 8.6) and separate serum protein, electrophoretically, into five major components (e.g., albumin, alpha-1 globulin, alpha-2 globulin, beta globulin and gamma globulin). The protein components are then further fractionated by immunodiffusion at right angles to the electrophoretic separation. This produces as many as 20 to 30 precipitin bands of various protein fractions, depending on the specific antibodies used in the procedure. The separation pattern of a normal human serum is shown in Figure 1.

Applications

A. Protein immunoelectrophoresis offers separation and identification of the following serum protein components:

1. Prealbumin
2. Albumin
3. Orosomucoid (alpha-1)
4. Heat-labile alpha-1 protein
5. Alpha-1 lipoprotein
6. Alpha-1 glycoprotein
7. Alpha-1 macroglobulin
8. Ceruloplasmin
9. Haptoglobins
10. Alpha-2 lipoproteins
11. Alpha-2 macroglobulins
12. Ba-alpha-2 glycoprotein
13. Beta lipoprotein
14. Heat-labile beta proteins
15. Transferrins
16. Beta-1A globulin
17. Beta-1C globulin
18. Beta-2A globulin
19. Beta-2M macroglobulin
20. Gamma X globulin
21. Gamma globulin
22. Group specific Gc-components

B. Protein immunoelectrophoresis offers the following clinical applications:

1. Identification of agammaglobulinemia
2. Classification of multiple myeloma by specific protein abnormalities
3. Identification of macroglobulin in Waldenstrom's macroglobulinemia

*Chief Pathologist, Methodist Hospital of Gary; Assistant Professor of Pathology, Chicago Medical School.

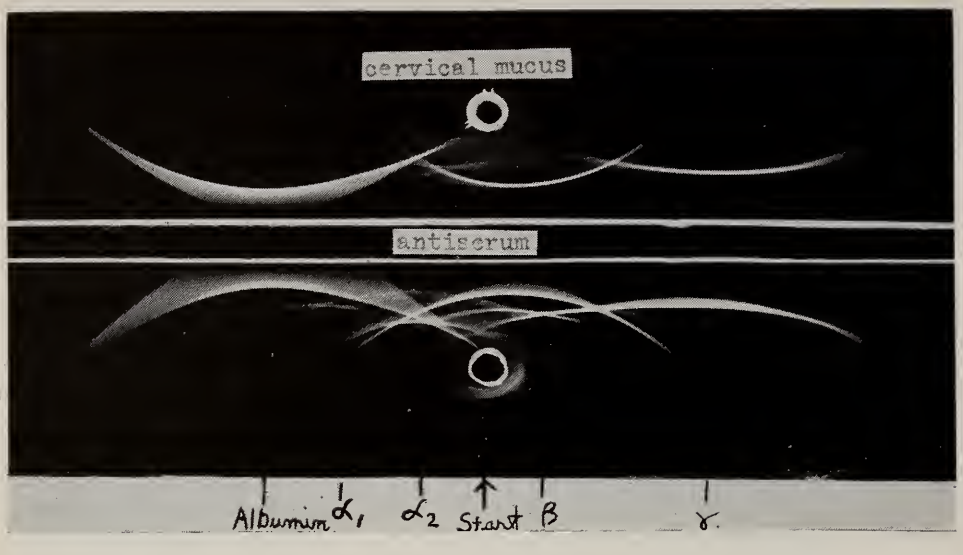


FIGURE 1
PATTERNS of immunoelectrophoretic separation. The bands between antiserum and specimen are specific precipitin bands. The bands in the lower one-half came from normal serum. (Photo courtesy Dr. Gebhard Schumacher, Chicago. Ill.)

4. Detection of hypoceruloplasminemia in Wilson's disease

5. Detection of increased spinal fluid gamma globulin in multiple sclerosis

6. Determination of immune globulin levels in lymphomas and leukemias

7. Localization of specific blood group antibodies

Recently it was found that cervical mucus from non-pregnant uterus has three major protein components (e.g., albumin, transferrin and gamma globulin). During pregnancy the cervical mucus shows presence of alpha-1 lipoprotein and disappearance of albumin and transferrin. Much research is still going on in different fields and more clinical applications are anticipated in the near future.

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Devoted to the interests of the medical profession of Indiana

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A Priceless Protection

SAFETY LENSES for everyday glasses is the recommendation of the National Society for the Prevention of Blindness.

Accidents involving the eyes occur in the United States at the rate of better than 1,000 per day. More than 300,000 adults and also 145,000 children each year run the risk of losing their sight because of shattered glasses.

Corrective lenses made of shatter proof glass or equally effective shatter proof plastic, mounted in strong and flame-resistant safety frames, are only a little more expensive than ordinary spectacles and a thousand times as safe.

Such safety glasses are practically the same weight as ordinary ones; they have the same appearance; and can be ground to any prescription, including bi-focals and tri-focals. Lenses and frames made to industrial specifications are the only ones recommended.

Years of experience in the protection of the eyes of industrial workers has demonstrated the sight saving potential of properly built safety glasses. In fact, the way safety glasses, both with optical correction and without, have protected the eyes of workers makes the wearing of shatter prone lenses by non-industrial people seem postively dangerous.

Proof that the wearing of shatter proof lenses is effective is provided by the Wise Owl Club of America, an organization sponsored by the national society and boasting more than 25,000 members, each one of whom has been in an accident and had his sight preserved because of such lenses.

The fact that safety glasses can be dropped without damaging them more than offsets the increased cost.

Safety lenses without optical correction are recommended for students in shops and chemistry labs, for athletes and for handy-men-around-the-house with power mowers and other power tools. That is, without correction for those who do not need correction, and with corrective lenses for those who do.

Actually, any American, living in such an active and vigorous environment, could benefit from the use of safety glasses.

Keep The Heart Beating

THE HEARTBEAT of a city is in its hospitals.

And, as a city grows, so grows its need for hospitals. For Marion County General Hospital, which must provide not only a great portion of the emergency needs of Indianapolis but which must as well provide care for the indigent, this city's growth has created problems.

No major additions to this hospital, that serves more than 190,000 persons annually, have been made for 25 years. Some of its buildings are a half century old. Marion County General *must* either expand and modernize or face loss of its accreditation because of crowded, outmoded and inadequate facilities.

The Citizens Committee for Marion County General Hospital, a group which includes many of the city's top business, civic, government and religious leaders, is seeking public support of a plan to float a $16 million bond issue to bring this community facility up to 1964 standards. The situation for General is a serious one. Unless public support for the proposal is given, the Marion County Health and Hospital Corporation will have no alternative but to ask for costly emergency appropriations to try to renovate facilities that do not meet minimum standards, or close them.

Such action could mean that the intern and residency training programs for the city's young doctors, as well as the nurses' training programs would have to be abandoned, leading to an ultimate abandonment of the hospital itself.

This must not happen. For it to do so would throw an insurmountable burden on the city's private hospitals that might well result in medical chaos for Marion County.

To taxpayers, who must bear the cost, the amount will be small for the benefits received.

The Citizens Committee estimates that the 20-year cost to the average homeowner, who has a $15,000 house, would be $2.95 a year—less than 1 cent a day to provide for this expansion which can benefit everyone in the county. And a $4 million gift pledged by Eli Lilly & Co. will pay the interest on the bond issue over the 20-year period lessening the final cost.

The drive to bring General Hospital up to 1964 standards is in a good cause. It deserves your support.—*Indianapolis Star*, Jan. 13, 1964.

Fiat Lux

SOMEHOW, in exhortations regarding traffic accidents, the emphasis has been shifting in recent days from *prevention of hazards* to amelioration of injuries. Hence, all the hue and cry about seat belts, padded instrument panels, etc. Now, this is all very well (I myself have been using seat belts for years) and even further safety devices to minimize injury are possible; but let us not forget that an ounce of prevention is worth a pound of cure. At this season of gloomy days and early dusk, hazards from poor visibility are upon us much of the time. Many drivers forget (or simply refuse) to turn on their lights until it is black night, forgetting that others may not have the ability to see well in half-light even though the former may be blessed with super-sight.

Early in 1963, a movement was started to equip automobiles with a "running light" near the center of the front of the car. This was urged after the favorable experience with such lights of a well-known bus company, which reported a reduction in daytime accidents of 15% over a two-year period. The running light is wired through the ignition, so that it burns whenever the motor is running—thus cannot be forgotten.

We have watched this development with interest and approval and are convinced that this is really a valuable safety device. It definitely calls one's attention to the

presence of another car, even in bright sunshine; and often sooner than one would otherwise see it. Even if this difference is only a second or two, the warning is valuable, and usually ample. It is also an aid in determining whether a distant car is headed toward or away from you—and this is crucial in modern high-speed highway travel. In our experience, a car approaching at right angles on a side street is seen at least two to three car lengths sooner if it has a running light.

It seems to us that physicians who spend so much time driving a car should be interested in *every* practical means of accident prevention. The idea of a running light (long in use by the railroads) is therefore being brought to the attention of our membership.

If you will but notice how these lights attract your own attention, you will want to equip your own car the same way.

A. W. Cavins, M.D.
Terre Haute

The Care and Feeding of Patients

EVERY DOCTOR is "most popular" with his patients, especially the hospital patients. The doorway of the hospital room is watched eagerly by them and every ear is strained for the footsteps of their doctor. He is the man of the hour!

The physician can soon lose his popularity with his following if he wastes his "hour." Each of his patients goes through the ritual and routine of everyday hospital life. Needles, gushing and spouting tubes, massages and backrubs are suffered or enjoyed. Like the kid who sings "All I want for Christmas is my two front teeth," the patient laments "All I want today is to see my doctor." Then the "star" arrives, and what he does is the great question.

All we sell is time and service. We hawk no product and we hustle no certain "brand name merchandise." We do try to help our patient get ease from DIS-ease. This is what we sell. How we sell it can make the difference between more or less DIS-ease in our patients. Each patient thinks he is the sickest and deserves all your attention. Each patient is the sickest unto himself and requires a lot of time and consideration. Too many of us flit into the room, mumble a few words, wave our hands about and leave. The dust and bedsheets flap about in the whirlwind of our departure. The patient sits with his mouth wide open trying to ask his first question. All he sees before him is the blank wall. "Where did he go?" wails the patient.

His revenge comes when you present a bill — "Where were you and what did you do for me? I saw only your shadow. Besides," they complain "what's wrong with me? What did you ever find out?" Too late you realize how you failed your patient. You lost your "man of the hour" award.

Explanations, diagrams and discussions with our patients are the basic part of treatment. All his questions need to be heard and answers given. We need to inform, instruct and interest these people in getting well. They may need sympathy or a spank, they may need encouragement and uplifting. They may need understanding and kindness, but they need their doctor. They need you, your helping hand, your healing touch.

Patients do compare doctors. One brags, "My doctor really has a bedside manner." His room-mate moans, "Mine has bedside manure!" What's your rating, Doctor?—George N. Lewis, M.D., Co-editor, *The Lake County Medical News,* October, 1963.

Editorial Notes . . .

The National Fire Protection Association is giving special emphasis this year to the prevention of fire in nursing homes and other homes for the aged. Percy Bugbee, general manager, says that "six years ago the association said that homes for the aged were in the unenviable position of first on the list of unsafe places to live. This is still true today." It's been said before that fire is a terrible thing, and especially so in a hospital. To this add "and even more so in a hospital for aged and disabled people."

Prices of prescription drugs dropped again last year. The Bureau of Labor Statistics announces that the consumer price index for drugs fell from 93.8 a year ago to the present level of 92.6. The figures are in relation to the price level of 1957-1959 which was set at 100. The price of the anti-infective group of drugs has fallen the most and is now at 81.9. While the price of drugs goes down, the price of almost everything else is rising steadily.

More than 170,000 chemicals have been checked in the search for anti-cancer drugs. One of the results is a group of five different chemicals, each one of which is capable of causing the complete disappearance of all evidence of leukemia. While not curative, these substances will provide long periods of palliation. Dr. Sidney Farber reported this progress to the Life Insurance Association of America and predicted that the day would come when the problems of cancer would be no more. In reviewing factors linked to cancer, Dr. Farber emphasized two —cigarettes and viruses.

Farmers lose more workdays due to disability than any other type of worker. They lose an average of 7.4 days per farmer per twelve months, 1.7 days more than the 5.7 days lost by city workers. The Public Health Service thinks the difference is due to the fact that there are more older persons engaged in farming plus the fact that they can rearrange their work schedule to take a few more days off. Another reason might be that farmers tend to have accidents resulting in greater incapacitation and lengthier convalescense.

The American Pharmaceutical Association and the U. S. Public Health Service are conducting a joint survey to determine the feasibility of the community pharmacy as a source of family health information. Three-hundred and sixty cooperating pharmacies, located all over the U. S., have installed special display racks which are stocked with public information pamphlets, eleven pamphlets per month. The health literature is supplied by more than 30 national professional and voluntary health agencies and has been carefully screened for accuracy and reliability. The program will continue for several months.

The Indiana Pharmaceutical Association has adopted a resolution which approves the labeling of medication with its name if the prescriber specifically requests it. In the absence of such a request, the resolution states that the pharmacist should not label medication on his own volition nor upon the request of the patient.

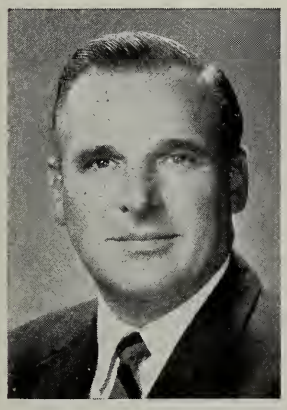
Professor Harry Pardue of Purdue University recently described the advances in the automatic measurement of chemicals and enzymes in body fluids. Methods are now quicker, more accurate and less expensive than the old manual methods. The old test for measuring glucose levels does not distinguish glucose and galactose. The new test measures both sugars in the same solution. Protein-bound iodine also may be measured more accurately by the new means. Results of some of the tests are obtained in a matter of seconds.

Carte blanche credit card holders will have payment of the first $200 of their in-patient hospital account guaranteed by the Hilton Credit Corporation, in case the hospital is unable to collect the account within 90 days. More than 1,200 hospitals in the U. S. are participating in the program. The program was developed as a convenience for credit card holders and is expected to be especially advantageous when the card holder is hospitalized in an emergency situation or while on a trip.

The overall voluntary support of American medical schools from individual doctors, from the AMA Education and Research Foundation, and from the National Fund for Medical Education has increased by 133.7% from 1955 to 1962. The total has risen from about 4.5 million dollars to more than 10 million dollars. Physicians may take pride in the fact that the doctor portion of the aid has risen by 157.8%, while the business and industry part (National Fund for Medical Education) has improved by only 88.7%.

President's Page

President Johnson has endorsed the medical care for the over age 65 program to be paid for under Social Security. He feels that this is an insurance program. The American people must be told again that this program is a tax on all of us. Who pays? We *all* pay! The guaranteed reserve payment does not exist in the Social Security mechanism and as we know it in private enterprise—nor does it guarantee the total medical care to which this country has been accustomed. This type of medical program under Social Security is not free. It is compulsory. It will lead to a total socialization of medicine in America. Can you, the American people, afford a lowering of the quality of medical care in the United States? The medical care, as it exists in England today, is abysmal. The English are now rejecting it! This type of program is President Johnson's program.



Chairman Nikita Khruschev stated that "We shall bury the United States." What he meant was that our country through the indifference of the intellectually complacent would first quietly socialize our government programs and then later Communism would take over. War is not necessary to accomplish this end. The American people do not want this to take place.

One way the Indiana State Medical Association can combat this distorted viewpoint is by increasing its Student Loan Fund. This has been accomplished. The Student Loan Fund of our Association will by 1968 have over a million dollars available to lend to needy medical students. The future doctors of our state will be well trained in medicine. Philosophically and economically they will be apprised of the pitfalls of Communism.

What is your freedom worth to practice medicine as you now are doing? Contribute generously to I-HOPE and AMPAC.

Donald E. Hood

The Woman's Auxiliary

REPORTS TO ISMA

Is our Freedom and Free Enterprise worth fighting for?

This is the question we must all ask ourselves within the next few days. The hearings on the King-Anderson bill resumed in January, having recessed on the fifth of the scheduled nine days. According to an article in *The AMA News,* election-year pressures inevitably will build up to push the King-Anderson bill, and there is no doubt that there will be a very powerful drive for passage of the legislation. A strong counter-drive will be needed to stave off the bill next session.



"Operation Hometown" represents Medicine's challenge to the King-Anderson bill. The auxiliary members have assisted the county medical societies with this program when asked, and are now busy with a "letter-writing to congressmen" campaign.

Edward R. Annis, M.D., President of AMA, addressing the House of Delegates said, "It is important for all of us to recognize that while millions of our fellow citizens are with us, there are thousands who do not comprehend the issues, who can't even tell you the difference between the King-Anderson bill and the Kerr-Mills law. Our task is to reach these people, and it is a job for each of us individually. When all else is said, it is the people who will decide this issue."

I hope we are totally prepared to meet this challenge as the forces propelling this legislation have worked diligently and unswervingly.

NOW may be our last opportunity to assume our task so we need never recall those sad words, "It might have been."

Zelda K. Sullivan

who were the "untreatables"?

From their inception with cortisone, to the present-day variants of the steroid molecule, the corticosteroids have presented a therapeutic paradox. The beneficial action against inflammation and allergy as well as several undesirable metabolic effects are all, apparently, the results of the same basic physiologic action.[1]

Some of these associated metabolic reactions made it risky or otherwise undesirable to treat with steroids large numbers of patients in various categories who would otherwise have benefited from such management. These "untreatables" were overweight, had cardiac disease, hypertension, or pulmonary fibrosis associated with congestive heart failure. Also in this category were those patients whose emotional symptoms were aggravated by earlier steroids.

But the advent of ARISTOCORT® Triamcinolone in 1958—the result of biochemical and pharmacologic research which successfully stripped away many important undesirable hormonal effects from the primary anti-inflammatory action—dramatically changed this picture. This steroid did not overstimulate the appetite, or cause the excessive weight gain induced by other steroids;[2-7] it proved to have one of the best records of any steroid for *not* causing edema, or salt-and-water retention;[2,3,7-10] and the incidence of undesirable euphoria with this agent was remarkably low.[2,4,5,9,10] What is most significant is that these benefits have stood the test of more than 5 years of widespread use. And, of course, the avoidance of these distressing hormonal effects benefited *all* patients requiring steroids, not just those in the special categories, as demonstrated by wide clinical use.

Side Effects. Since it may, under some circumstances, produce any of the unwanted effects common to all cortisone-like drugs, discrimination should always be exercised in administering ARISTOCORT® Triamcinolone. Any of the Cushingoid effects are possible, as are purpura, G.I. ulceration, increased intracranial pressure and subcapsular cataract. Corticosteroids generally may mask outward signs of bacterial or viral infections. Catabolic effects to watch for include muscle weakness and osteoporosis. Weight loss may occur early in treatment but is usually self-limiting.

Contraindications. While the only absolute contraindications are tuberculosis and herpes simplex, there are some relative contraindications (peptic ulcer, glomerulonephritis, myasthenia gravis, osteoporosis, fresh intestinal anastomoses, diverticulitis, thrombophlebitis, psychic disturbance, pregnancy, infection) to weigh against expected benefits.

While no steroid can *cure* a susceptible disorder, many patients who would otherwise be confined in a state of invalidism have, on ARISTOCORT® Triamcinolone, been able to pursue active, useful lives.

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The American Public and Medicine

A Doctor Speaks His Mind

ROBERT P. ACHER, M.D.
Greensburg

THERE ARE SEVERAL considerations of certain aspects of the practice of medicine that never seem to come to public appraisal or attention in the lay or professional press. The reasons for this may be that these considerations or facets of the practice of medicine are not flattering reading, or that they are qualifying and unpleasant parameters that detract from the newsworthiness of the subject. It may be that these considerations require the reader to think objectively and this may make him a little uncomfortable, or that they are contrary to popular prejudices.

But whatever the reasons, it is becoming increasingly necessary to the survival of good medical care and the health of the Nation that some of these considerations be publicized, thought about, acted upon and realistically appraised by many people—trained and untrained, educated and uneducated.

Here are some of the aspects that should be considered:

1. The scarcity of family doctor general practitioners.
2. Doctor usage.
3. High cost of medical care.
4. Health legislation and individual responsibility for health.

Has anyone ever stopped to consider that our medical schools are not training family doctor general practitioners of medicine any more? From the time a prospective doctor enters pre-medical and medical school, he is directed toward specialization. He is taught by specialists, and advised by specialists; specialists are the only people he has contact with during his training and apprentice period. It is little wonder therefore that there are no family doctor general practitioners being trained.

The medical schools, where future doctors train, have insufficient knowledge of what general practice—family doctoring—is; they cannot define or describe it. Let us face it—neither the AMA, the American Academy of General Practice, nor even the general practitioner himself can render a uniform, consistent appraisal of just what the general practice of medicine is. Until this is given a uniform, consistent, comprehensive definition and understanding by medical schools, medical societies, hospitals, hospital societies and the public, no one in his right mind will ever start out to be a general practitioner. (Apologies to those of us who are at present representing ourselves as general practitioners.)

The Piecemeal Patient

By the time the specialist gets through his training, he is so satisfied with his very extensive knowledge of his specialty and so enamored with his little or big segment of medical knowledge that he is convinced that no one should ever undertake the slightest procedure involved in his specialty, except someone trained, like himself, to do the most complicated procedure; and thus, it becomes a closed field. It also becomes twice as expensive and difficult and perplexingly complicated to the patient.

Hospitals, medical societies, medical schools, other specialists, and even the public support him in this. But there is one question that the specialist cannot answer, that is, "Who should decide when and what specialist the patient should see?" Even the specialist himself is not quite willing to say that the patient should decide this. Many specialists may accept the patient's decision in this matter for practical or other reasons. He then may get so engrossed in his "special part" of the patient that he may completely overlook the "whole" good of the patient; or he may refer the patient to another specialist and thus the patient may go the rounds of the specialists—never having his whole

medical story evaluated comprehensively. The total picture may never be put together for his benefit and his best medical management.

There is a place for the family doctor general practitioner, but until this ill-defined place in the total medical picture is defined in such a way that medical schools, hospitals, specialists, the general practitioner himself and the public understand it and give it meaning and stature, there will continue to be a shortage of general practitioners.

It should be noted that much of the antagonism toward the medical profession engendered by "not being able to get a doctor" is rooted in some very complicated human relationship problems. It may stem basically from immature wish fulfillment, unrealistic fears and guilts of which the American public and the doctors seem to have an undue share.

Rights and Responsibilities

The public is beginning to feel that medical care is a right, not much different from such well-established services as education, fire protection and public roads, never stopping to consider that *whoever* pays for it—no amount of legislation, provision of facilities, scientific equipment, highly trained specialist, etc.,—will avail them one whit toward health and good medical care unless they assume their responsibility in utilizing the medical care available. The public, both political parties and even the President fail to recognize the difference between the right of medical care, the individual responsibility that right demands, and the individual responsibilities involved in the other public protections and services furnished for the public weal.

The politician and the public speak glibly of rights, never mentioning or facing up to the responsibilities that these rights imply. When it comes to the rights of medical care and health, it is impossible to separate the individual *responsibilities* from these *rights*. I have never heard the proponents of government supplied medical care mention the tremendous individual responsibilities in their eulogies of their concept of the ideal publicly supported, medical care program.

It is never mentioned that many expensive, painful and disabling illnesses would be wholly unnecessary were the individual to assume his responsibility for having a yearly medical checkup, paying informed attention to early symptoms, seeking—and following—medical advice and attention before the illness develops into an expensive disabling or prolonged affair. The doctor and the present system of medical care absorbs much unjust criticism from this lack of thinking on the public's part and absorbs much of the guilt associated with it.

Can anyone think for a moment that legislation, taxes or any amount of facilities could change this? *Only honest public assessment and realistic education can make any dent in this problem.* Here is where the medical profession is, in some degree, responsible for this dilemma, by not taking time to carefully explain in a meaningful and sincerely thoughtful way the factors involved in the patient's usage of the doctor. The vast majority of doctors do wish to render the best medical care possible to their patients but, by not giving basic thought to wherein the patient's best interest lies, they permit patients to have wholly unrealistic expectations of them. They thus promote unrealistic and excessive usage of themselves, which, eventually, they cannot fulfill resulting in much criticism.

On the other hand, the public today is medically informed and misinformed by the lay press and is so willing to read meanings into the articles published on medical subjects—meanings and conclusions that were never intended by the authors or publishers —meanings that are motivated by immature wishful thinking, denials and unrealistic fear—that it becomes a real problem for the doctor to steer his patient through the maze of modern medicine and remain true to himself and the patient.

A little more effort and willingness on the part of the doctor to accept himself realistically and to rid himself of the unrealistic fears he may have of what the patient may think if he does this, combined with a little more effort and willingness on the part of the public to accept their doctors realistically and not have unrealistic expectations of them, could have very wholesome and useful benefits both for

the individual and for the national problems of health and medical care.

The Cost for Living

As to costs of medical care, more realistic usage of doctors and facilities might properly reduce costs a great deal. Even so, more meaningful thinking and basic appraisal by the individual, the public, and by those concerned with medical care and health in general, of what is important to them individually and collectively, related to how they spend their money, makes even present costs seem rather unimportant in spite of all the hue and cry about these costs.

When one stops to consider that the American public spends approximately:

$9,600,000,000 yearly on alcoholic beverages
7,050,000,000 yearly on tobacco products
2,700,000,000 yearly on toilet articles and preparations
2,100,000,000 yearly on jewelry and watches
1,280,000,000 yearly on admissions to motion pictures
500,000,000 yearly on parimutuel net receipts
250,000,00 yearly on admissions to spectator sports

All these items may be of some importance in daily living but, when compared to health, that basic commodity without which they become more or less meaningless, even the present costs of medical care become much less excessive.

Defensively, each individual may say, "Yes, but I don't spend excessively on alcoholic beverages, tobacco products, toilet articles and preparations, jewelry and watches, admissions to motion pictures, parimutuel net receipts or admissions to spectator sports," etc. All I can say to these individuals is that when amounts of this magnitude are spent on these things, it has to involve a great many people as just a few couldn't spend that much. Please think again and reappraise what is really important to you and what you spend your money for. And please don't transfer your resentment at being sick or having some unforeseen medical calamity befall you to the doctor or the other people or institutions involved in trying to help you restore yourself to health—maybe it is worth what you have to spend on it.

Obviously, everything said in this article, except the statements relating individual responsibilities and health, can be refuted, denied and questioned with authoritative references by certain areas, groups and individuals; but the appearance of such an article as "The American Doctor" in *The Saturday Evening Post*, July 15, 1963, and many other similar articles in other publications certainly would seem to indicate that there is a real problem in regard to medical care.

How it is dealt with depends on how we think about it. To think realistically about it, we need all the information, facts and approaches we can muster. We also need to eliminate our personal prejudices (almost an impossible thing for a human being to do); but, most of all, *we* have to think—*more people* have to think, and think as clearly as possible. Interchange of ideas and friendly expression of thoughts are the only ways to effectively manage a problem in a democracy like ours.

In this article I have tried to express some thoughts—if they stimulate more realistic and useful thoughts, it will have accomplished its purpose. If it promotes more realistic and useful actions, it will have more than accomplished its purpose.

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In Sprains, Strains and Muscle Spasm, 'Soma' Compound

numbs the pain...not the patient

A potent analgesic and a superior muscle relaxant

1. A sprain or fracture is not a big clinical problem—but it does hurt. And if there is housework to do and kids to mind, the patient needs something to numb the pain.

2. A.P.C. compounds have limited usefulness; and the patient can buy them without your prescription. Unfortunately, most of them are too mild to be effective for sprains—and more potent products too often make the patient feel 'dopey'.

3. 'Soma' Compound is ideal in these cases. Since it contains both 'Soma' (carisoprodol) and acetophenetidin it is both a potent analgesic and a superior muscle relaxant; it also contains caffeine to offset any drowsiness *("numbs the pain... not the patient").*

4. Why not try 'Soma' Compound? Dosage is 1 or 2 tablets q.i.d. For more severe pain, try 'Soma' Compound + Codeine. Dosage: 1 or 2 tablets q.i.d.

5. Hypersensitivity to carisoprodol may occur rarely. Codeine may produce addiction, nausea, vomiting, constipation or miosis.

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Soma® Compound + Codeine

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning—may be habit forming.)

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DAY BY DAY WITH THE F D A

From the FDA Reports on Enforcement and Compliance.

Dr. William F. Koch devised a new treatment for cancer in 1914 and named it "Koch's Glyoxylide." Subsequent chemical tests showed that it was indistinguishable from sterile distilled water. Koch was tried twice; the trial ended in a hung jury the first time and a juror became too ill to finish the second trial. The doctor then took off for residence in Brazil. Later the FDA received a letter from him saying in part "there is a chiropractor in Palestine, Texas, advertising 'Genuine Koch Glyoxylide for cancer patients is available.' It is your duty to prosecute this crook. Sincerely yours, Wm. F. Koch." FDA just did and the crook was found guilty.

* * *

U. S. marshals recently seized a 34,000 pound supply of salvaged sugar in Kansas. A freight train wreck had dumped the sugar together with a shipment of boron along a right of way, previously contaminated with arsenic. The salvager was selling it to bee keepers, who complained to the authorities that it was killing bees by the hiveful all over four states.

* * *

The Strontium-90 content of food is still well within the limits set by the Federal Radiation Council as acceptable for lifetime consumption, although the U. S. diet has increased a little in Strontium-90 content since May, 1961. FDA studies Strontium-90, Cesium-137, pesticide residue and vitamins every three months by purchasing in the open market in each of five major cities approximately 60 pounds of groceries, a week's ration for a 16-19 year old boy, and analyzing the food for what it should and should not contain. The foods purchased constitute a balanced diet for the "moderate income" level. An interesting finding is that the waste segment of the diet constitutes only six percent by weight but contains fifty percent of the Strontium. The other fifty percent is in the dairy products.

* * *

"Tex" Palmer and his son "Bill", previously convicted of distributing counterfeit drugs and on probation at the time, were recently caught by the FDA in possession of nearly a half-million amphetamine tablets in Houston, Texas. Inspectors not only found the drug supply but witnessed several sales. Result: jail sentences and more probation on release.

* * *

Will H. Roberts of the Roberts Health Center of Evansville has been found guilty of shipping drugs misbranded with false and misleading claims for the cure of cancer. He was sentenced to two years in jail, suspended, placed on two-year probation and fined $650 and costs.

* * *

FDA this summer completed a painstaking laboratory analysis of Krebiozen and determined that it was composed almost, if not completely, of creatine. Creatine is a normal metabolite of the body and is produced in one person during 24 hours of metabolism in the amount equivalent to 100,000 ampules of Krebiozen. It has previously been tested for its effect on neoplasms and found to be inert for this purpose even in tremendous doses.

* * *

Amphetamine traffic was slowed in separate actions in Indiana when an M.D. was relieved of a stock of 273,802 tablets and a truck stop proprietor was fined $1,000 for peddling the drug. The doctor was charged with violation of the regulation which requires labeling of containers with directions for use, it being inferred that the amount in his possession was too large to qualify for an exemption as a practitioner's stock for normal dispensing.



When you prescribe for nasal congestion...

remember 'Empirin' Compound to relieve common cold discomfort



Also: 'Empirin'® Compound with Codeine Phosphate*
gr. ⅛—No. 1/gr. ¼—No. 2/gr. ½—No. 3/gr. 1—No. 4
*Warning—may be habit forming

Medicine At Law

DECISIONS AND OPINIONS

Highlights of recent court actions pertaining to health and medicine from *The Citation* prepared by the Law Division of AMA.

Delay in Skin-grafting of Third-degree Burns Held Negligent—In a malpractice suit against a hospital and its chief surgeon for negligence in the care and treatment of a minor for third-degree burns, an appeals court sustained a judgment of $35,000 for the minor and $6,500 for his father. The court said that testimony of a doctor that better results are usually obtained by using thin skin grafts early in the treatment of such burns was sufficient, in conjunction with other evidence as to the standards of practice in such cases, to permit the jury to find that the doctor and the hospital were guilty of negligence resulting in injury to the patient.

The patient, a six-year-old boy, was brought to the hospital emergency room 15 minutes after he had suffered extensive burns. Thereafter, he was placed in a 10- or 12-bed ward in the hospital, where he remained for 53 days, in the care of the chief surgeon. At the end of that period, the chief surgeon told the patient's father that the hospital did not have proper facilities and equipment to care for such serious burns, and the patient was transferred to another hospital.

There was expert testimony that the standard of practice in treating third-degree burns required, among other things, placing the patient in isolation to prevent infection, commencement of skin grafting as early as possible, and the use of thin, rather than "full-thickness" grafts. In this case, the surgeon did only one very limited "full-thickness" graft, delayed four weeks, leaving 99% of the third-degree area uncovered. The third-degree area, which covered 18% of the patient's body at the time he entered the hospital, had increased to 25% of his body at the time he was transferred to the second hospital.

In the major areas controlled by standard practice, the evidence was clear, the court said, that the surgeon had failed to exercise reasonable care. As a result, the patient underwent extended hospitalization, numerous additional surgeries, and repair work to correct deformities, suffering extensive and severe permanent scarring.

The court pointed out that in malpractice cases it is not necessary to prove conclusively that the physician's negligence resulted in injury to the patient, but only to present substantial evidence that the negligence caused the injury. In this case, expert testimony as to the standards of practice in treating third-degree burns, and expert testimony that better results are usually obtained in treating third-degree burns by using thin skin grafts at an early stage of treatment, tended to prove that failure to conform to such standards resulted in the patient's serious condition. *Carrasco v. Bankoff,* 33 Cal. Rptr. 673 (Cal., Sept. 16, 1963).

Private Hospital Privileged to Remove Doctor from Staff—Where there was no claim of failure to conform to procedural requirements of a private hospital's bylaws or other rules, the hospital could lawfully remove members of its medical staff at will.

In so deciding, a federal trial court held that a private hospital is one which no government agency takes part in controlling. The fact that the hospital was constructed with public funds and was later conveyed to a private corporation did not make it a

public corporation. Likewise, the facts that the hospital received donations or compensation from government agencies for the care of indigent persons, and that it was operated not for profit, did not make it a public hospital.

The case arose when the hospital failed to renew the membership of a physician on its "courtesy staff." Appointments to the courtesy staff were made for a period of one year and were renewable from year to year. Members of the staff were permittted to recommend their private patients for admission to the hospital and to attend to them there.

After five years on the staff, the doctor's appointment was not renewed, and he sued for reinstatement and damages. In ruling against the doctor, the court said that a private hospital may in its discretion exclude any physician from practicing in the hospital. The hospital's decision is final and is not subject to judicial review, except possibly where the exclusion violates the hospital's own procedural requirements. In this case, no such violation was involved. *Shulman v. Washington Hospital Center,* 222 F. Supp. 59 (D.C., D. of C., Oct. 9, 1963).

Federal Government Authorized to File Malpractice Suits—Under a law enacted earlier last year, the federal government may bring personal injury suits against persons responsible for injuries suffered by patients who receive hospital or medical care.

Title 42, U.S. Code, Sections 2651-2653 provide, that in any case in which the United States is authorized or required by law to furnish hospital, medical, surgical or dental care and treatment to a person who is injured or suffers a disease under circumstances creating a tort liability upon some third person to pay damages therefor, the United States shall have a right to recover from said third person reasonable value of the care and treatment so furnished, or to be furnished.

If the third party files suit, the government may intervene or join in the suit. If the injured party does not commence suit within six months after the first day of care

Continued

reduce or obviate the need for transfusions and their attendant dangers

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or treatment, the United States itself, may initiate the suit. In at least one case, the Veterans Administration has made a claim against the physician on the basis of alleged negligence in the treatment of a patient who was later hospitalized for care in a veterans administration hospital.

Statute Limiting Optometrist's Practice to Single County of Residence Held Invalid —A statute limiting an optometrist's practice to a single county—that of his residence —is unconstitutional, the Indiana Supreme Court ruled. The court decided that there is no justification in the public health, safety, or welfare to warrant such an exercise of the state's police power.

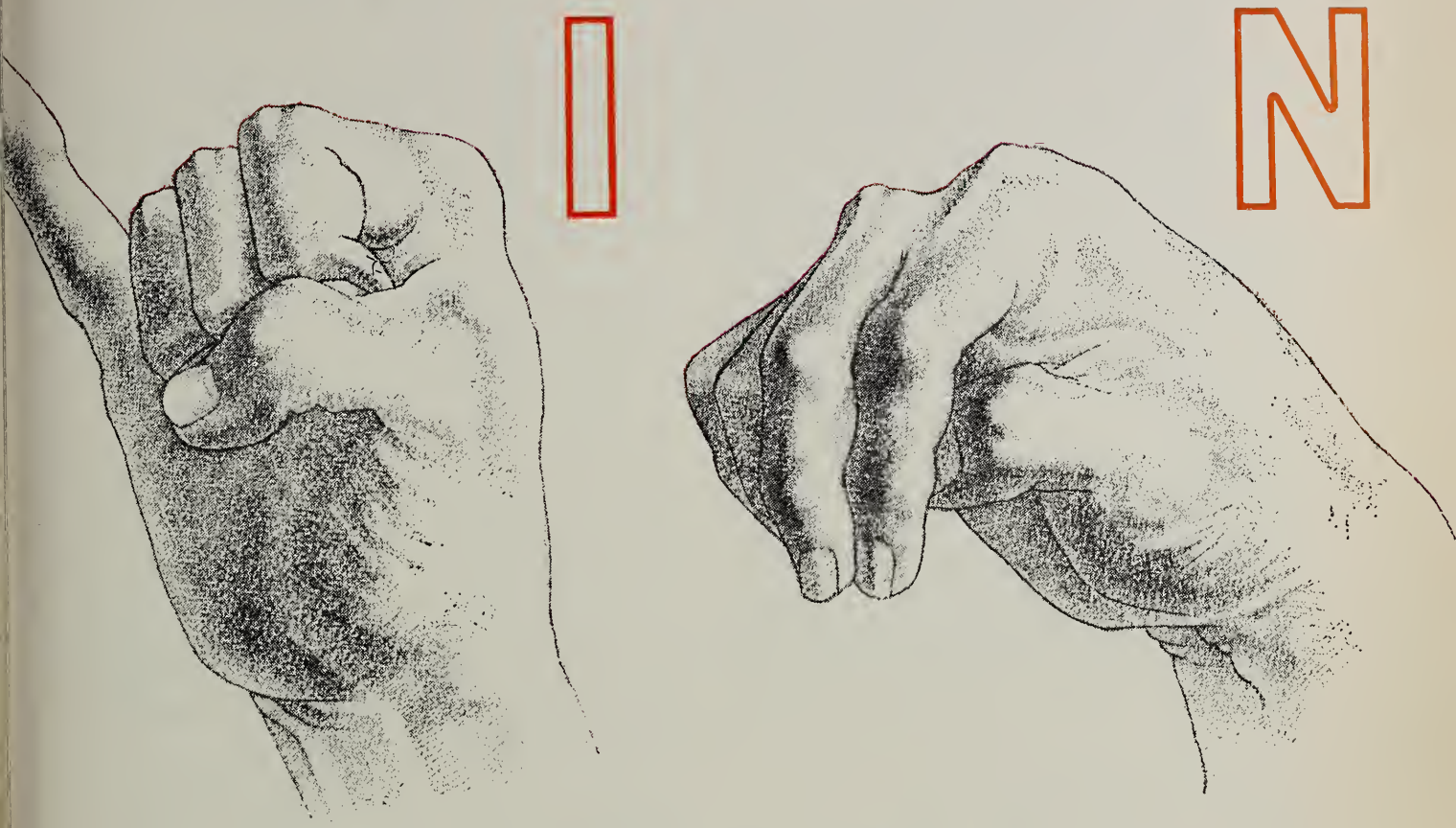
The court also held invalid that portion of the statute allowing the State Board to determine what acts, in addition to those enumerated in the statute, constituted "unprofessional conduct." Such delegation of authority was unconstitutional, the court said, because it was a complete abrogation of legislative power.

The rulings were made in a proceeding for judicial review of an adjudication by the State Board of Registration and Examination in Optometry. The State Board had ordered a six-months' suspension of an optometrist's license, on the grounds that he had accepted employment from a company selling optical goods and had benefitted from that company's cut-rate advertising.

The court concluded that the evidence did not support the allegation that the optometrist had accepted employment from the optical company. The optometrist's entry into an arrangement whereby he would occupy adjoining and connected office space with the optical company, advertising its merchandise, and whereby he would receive financial benefit from the arrangement through the company's generally referring prospective purchasers to him, and his generally referring clients to the optical company, did not amount to "unprofessional conduct" under the statute.

An allegation that the optometrist was guilty of unprofessional conduct in benefitting indirectly from the optical company's cut-rate advertising—a practice which the statute forbade optometrists to engage in directly—was dismissed on the ground that such practice was not explicitly forbidden by the statute. Punitive laws which would deprive an individual of the freedom to exercise his skills in a business or profession should be strictly construed, the court said. Before the state's police power is used to prohibit the conduct of an individual as "unprofessional," that conduct must either be explicitly defined as unprofessional or must fall clearly within the scope of the statute. *Cassidy v. Indiana State Board of Registration and Examination in Optometry,* 191 N.E. 2d 492 (Ind., June 26, 1963).

arthritic joints from



uty arthritis, rheumatoid spondylitis, osteoarritis, bursitis, fibrositis, and neuritis. Arthralgen ay be used for analgesia in colds, flu, and rious myalgias.

OSAGE: One or two tablets four times a day. ter remission of symptoms, dosage should be duced to the minimum maintenance level.

DE EFFECTS: Nausea, GI upset, or mild salicym may rarely occur. Symptoms of hypercorticoidm dictate reduction of dosage of Arthralgen-PR.

RECAUTION: Reduction in dosage of Arthralen-PR given over a long period should be gradual, ever abrupt.

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s with any drug containing prednisone, Arthralen-PR is contraindicated, or should be administered only with care, to patients with peptic ulcer, tuberculosis, nephritis, diabetes mellitus, acute psychoses, Cushing's syndrome (or Cushing's disease), overwhelming spreading (systemic) infection, or predisposition to thrombophlebitis.

Arthralgen-PR is generally contraindicated in patients with uremia and viral infections, including poliomyelitis, vaccinia, ocular herpes simplex, and fungus infections of the eye. It is also contraindicated in patients with chicken pox or susceptible persons exposed to it.

SUPPLY: Arthralgen (white, scored) and Arthralgen-PR (yellow, scored) tablets are available in bottles of 100 and 500.

*Cohen, et al: J.A.M.A., 165:225, 1957.

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ABSTRACTS

BOOK REVIEWS

TEXTBOOK OF NEUROLOGY

H. Houston Merritt, M.D., Lea & Febiger, Philadelphia, Pa. Third edition, 1963. 803 pages, 197 figures. $12.50.

This most recent, thorough and painstaking revision of what is probably already the most popular teaching monograph in its stated field will assuredly keep the book as the less and less disputed leader in teaching its chosen specialty. Prof. Merritt has that rare knack of stating facts crisply, critically and understandably. Sheer bulk is kept down, a good index makes easy reference a pleasure; unobtrusive yet authoritative summaries make even abstruse topics intelligible.

This edition incorporates the newest without too soon discarding the old. Excellent references at the end of each topic chapter give ready access to anyone wanting to pursue the subject to finer ramifications. Just spot checking such a big topic as COMA, the index led me successively to cause after cause—each time the reader was presented with a thoughtful discussion of the best consensus as seen by an inspired teacher. Dr. Merritt's vast erudition is transmuted in legerdemain fashion into an easily read book in which one is made to forget the vast complexities of the subjects!

Every practicing physician, teacher and specialist just about has to have at his fingertips an informative text on neurology; I recommend that it be Dr. Merritt's distinguished contribution.

ARNOLD LIEBERMAN, M.D.
New York, N. Y.

FUNGI AND FUNGOUS DISEASES

Symposium of N. Y. Academy of Medicine, edited by Gilbert Dalldorf, M.D., Charles C Thomas, Springfield, Ill., 1962, 335 pages, profusely illustrated, copious tables, exhaustive references after each chapter.

This eleventh symposium of the Section on Microbiology was held in March of 1962. Almost 30 experts participated in the proceedings; Dr. Dalldorf was the able editor of the final compilation. Charles C Thomas did an almost errorless job in putting out this beautifully printed and splendidly bound volume.

Even a casual glance at the table of contents reveals the excellent balance between the most esoteric erudition and the intensely prosaic practical knowledge. The teacher of microbiology is briefed on the latest in this growing field; at the end of each chapter, he is presented with a wealth of references for his further perusal. The practicing physician is given, in explicit and minute detail, the exact technics to be used in the treatment of his patients suffering with the ailments embraced within the title.

We are all acquiring an increasing awareness of the fact that fungi do not limit themselves to remote country areas; the city dweller in all regions of our great land *may* harbor a fungal infection. It is a mark of diagnostic competence for every physician to be aware of this. This monograph belongs on every hospital library shelf; many teachers in medical schools and internists in private practice will not only read this, but also make the volume a part of their shelf of books used daily.

Rarely can a reviewer recommend a book with such satisfaction: with no ifs, ands or buts.

ARNOLD LIEBERMAN, M.D.
New York, N. Y.

CURARE AND CURARE-LIKE AGENTS

Ciba Foundation Study Group, 1962. Little, Brown & Co., Boston, Mass., $2.95. 100 pages plus numerous figures.

The score of participants in this symposium were honoring Professor C. Chagas, one of the distinguished pioneers in this particular branch of pharmacology. As usual, this vest-sized booklet is the edited essence of each man's remarks.

Claude Bernard was happy to know that there was a "curare" effect; we have come a long way from that original thought. Now, we are concerned with such things as receptor sites; just what kind of electric forces are being exerted? And—precisely where? And how?

"I WEAR A HANGER LEG...



. . . yet ride a bike and ice skate, and have learned to roller skate, skip, and walk down the steps foot-over-foot."

Marion Phillips, school girl, began wearing a Hanger Hip Control Leg at the age of 10. The correct fit and dependable performance of her Hanger Leg have enabled Marian to take part in the normal activities of a teen-age girl. Her amazing rehabilitation is not unusual, others have been equally successful, and most Hanger wearers are able to return to a normal active life.

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The experts in the field have reached the stage of beginning to ask some penetrating questions: why is the steric configuration just such and just why does the magnesium as well as the calcium iron exert the effect they do? Is it only the chelation that re-enforces the blocking? How does the planarity affect the interacting molecules?

At present, we know enough to know that we are being confused by our overall ignorance. This volume throws a bright (and rather harsh) light on many of the complexities awaiting resolution. The specialist in this branch of pharmacology will enjoy studying the presentation. I cannot recommend it to the average physician: even the most earnest perusal will be frustrating. Some day, the subject will be really understood and teachable in simpler language. Until that happy time, I would suggest any good pharmacology text. In all frankness, I confess that this study group led me immediately into deep waters far beyond my depth.

ARNOLD LIEBERMAN, M.D.
New York, N. Y.

Abstracts From Various Literature, Prepared by AMA

ARE BENIGN GASTRIC ULCERS REALLY BENIGN?

Although the problem of distinguishing a benign from malignant etiology is always present in evaluating a patient with a gastric ulcer, a review of 474 gastric ulcer patients emphasized also the problem of the recurrence rate of at least 35% for benign ulcers. The use of available diagnostic methods and strict adherence to criteria in interpreting a brief therapeutic trial can nearly always prevent neglect of a malignant ulcer. The patient with a gastric ulcer responding satisfactorily to a therapeutic trial is in greater danger from recurrence of a benign ulcer with life-endangering complications than from malignancy. In our experience, if recurrence of a benign gastric ulcer occurred, approximately one-half required surgery. One-fourth of those operated on required emergency procedures.

Duhamel, P A., Block, M. A, Haubrich, W. S.: Are Benign Gastric Ulcers Really Benign?, *Arch, Surg.* 87:391 (Sept.) 1963.

COMPLICATIONS OF CLOSED CHEST CARDIAC COMPRESSION

In recent months there has been an increase in the number of reports of serious complications that were directly the result of vigorous force required to move the sternum posteriorly in order to produce an adequate compression of the ventricles. The most frequent injuries reported were fractures of the ribs and sternum, but there were also instances of damage to the bony thorax, pericardium, myocardium, kidney, spleen, aorta, large veins and liver. Many complications occurring at the author's

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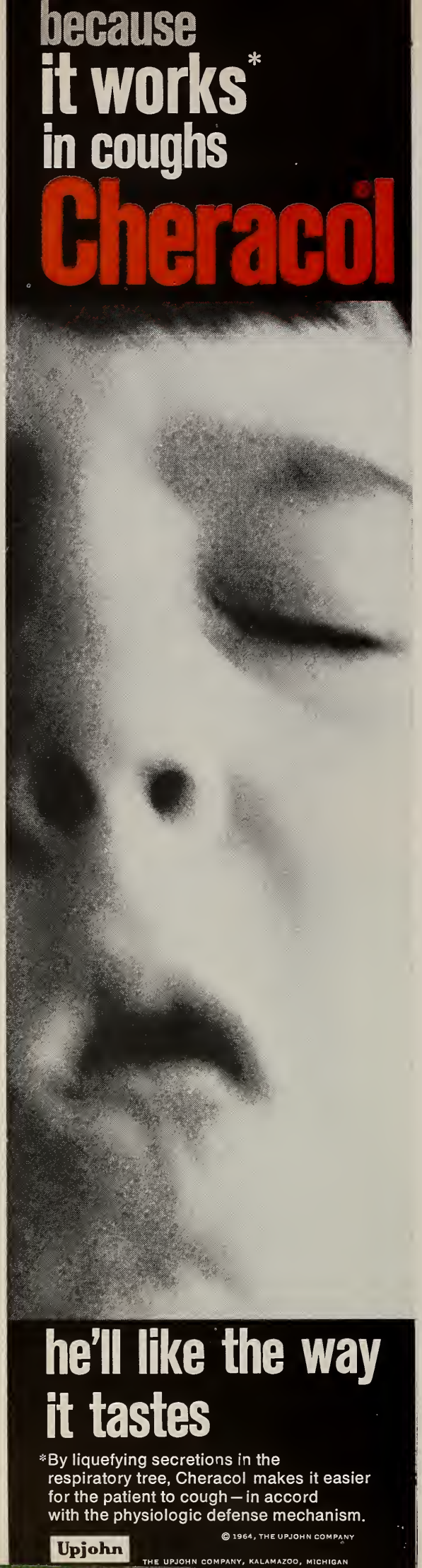
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hospital were due to lack of experience, haste, and unduly severe sternal compression. The survival rate was extremely low, owing to the presence of severe disease, but the few successes in patients whose survival seemed impossible, is encouraging. The author suggests that closed chest cardiac compression, combined with artificial ventilation, is the treatment of choice in cardiac arrest occurring in patients before hospitalization. There are conditions, however (stove-in chest, funnel chest, air embolism, cardiac tamponade, bilateral pneumothorax etc.), in which cardiac arrest should be treated by direct cardiac compression, whenever possible, rather than by closed chest cardiac compression.

Minuck, M.: Complications of Closed Chest Cardiac Compression, *Canad. Anaesth. Soc. J.* 10:259 (May) 1963.

CORONARY HEART DISEASE AMONG BUSINESS AND PROFESSIONAL MEN

Relative weight, body fatness, blood pressure (BP), and serum cholesterol of 281 healthy Minnesota business and professional men, initially aged from 45 to 55 years, are reported from 16 annual examinations, during which time the coronary heart disease (CHD) developed definitely in 32 and possibly in 16 others. Susceptibility to CHD was elevated among men above the median at first examination in any of these characteristics, but only cholesterol was statistically significant. Data for all predisease years showed significance for systolic BP and cholesterol. The few men with low cholesterol who developed CHD tended to be at the top of the BP and weight distributions. Similar data from other follow-up studies showed a high concordance. From 251 cases of CHD among 4,069 men, the risk of future CHD for men classed by cholesterol was correlated with the cube of cholesterol at $r=0.9$.

Keys, A., Taylor, H. L. Blackburn, H., Brozek, J., Anderson, J. T., Simonson, E.: Coronary Heart Disease Among Minnesota Business and Professional Men Followed Fifteen Years, *Circulation* 28:381 (Sept.) 1963.

SEVERE ASPIRIN POISONING

A method is described for treating acute acetylsalicylic acid (aspirin) poisoning by forced alkaline diuresis, and this form of treatment is compared with hemodialysis in two similar groups of patients with acute acetylsalicylic acid poisoning. Forced alkaline diuresis is shown to be comparable in efficiency to hemodialysis in producing clinical and biochemical improvement over the eight-hour period following diagnosis, if delays in obtaining use of the artificial kidney are taken into account.

Dukes, D. C., Blainey, J. D., Cumming, G., Widdowson, G.: Treatment of Severe Aspirin Poisoning, *Lancet* (London) 2:329 (Aug. 17) 1963.

SEPTIC SHOCK

Septic shock is defined as hypotension caused by bacteremia and accompanied by decreased peripheral blood flow, as evidenced by oliguria. Clinically a shaking chill is the warning signal. The immediate cause of hypotension is pooling of blood in the periphery, leading to decreased venous return; later the peripheral resistance falls and cardiac failure may occur. Irreversible shock is comparable to massive reactive hyperemia. Reticuloendothelial failure, histamine release, and toxic hypersensitivity may be factors in the pathogenesis of septic shock. Adrenal failure does not usually occur, but large doses of cortisone are employed therapeutically to counteract the effect of histamine release or hypersensitivity to endotoxin. The keys to successful therapy are time, antibiotics, vasopressors, cortisone, and correction of acidosis.

Lansing, A. M.: Septic Shock, *Canad. Med. Ass. J.* 89:583 (Sept. 21) 1963.

ANGINA PECTORIS WITH COEXISTING SKELETAL CHEST PAIN

Of 2,213 medical patients studied, 303 presented convincing clinical evidence of angina pectoris. An equal number of control subjects was randomly chosen on the basis of an absence of any cardiac disorder, and these subjects were paired as to age decade and sex with the patients of the angina pectoris group. Clinical evidence of anterior chest pain of skeletal origin was present in 51% of the patients with angina pectoris and 23% of the control subjects. In the former group, skeletal chest pain frequently occurred in the absence of a prior myocardial infarction. In a considerable fraction of the patients with angina pectoris the more important ischemic pain was confused with or even masked by the coexistence of the innocent disorder.

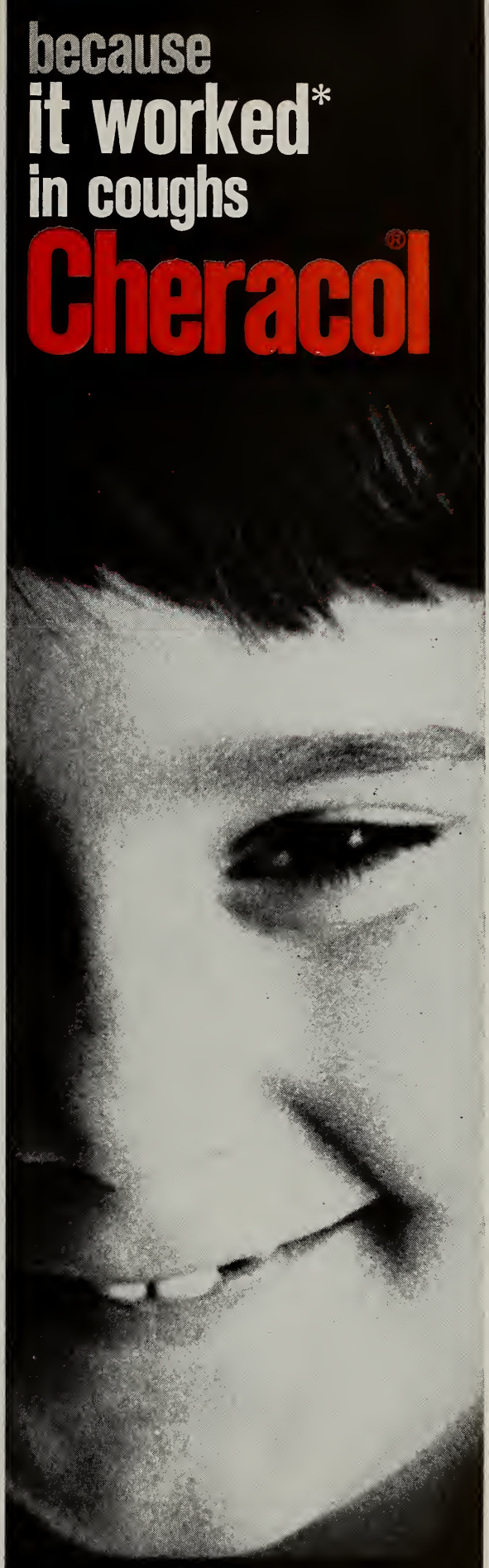
McElroy, J. B.: Angina Pectoris with Coexisting Skeletal Chest Pain, *Amer. Heart. J.* 66:296 (Sept.) 1963.

FIVE-YEAR RESULTS IN THE TREATMENT OF WILMS TUMOR OF CHILDREN

Of 30 patients with Wilms tumor in childhood observed from 1926 to 1956, 16 survived five years. The prognosis was better if the patient was less than two years of age when treated, if no evidence of capsule invasion was found, and if radiotherapy both before and after nephrectomy was added. Although the number of patients reported is too small for any definite conclusions, it would appear that radiotherapy is of greater importance pre-operatively than post-operatively. Such a conclusion would be consistent with expectations derived from an appreciation of the extremely aggressive and radiosensitive behavior of these tumors.

Vaeth, J. M., Levitt, S. H.: Five-Year Results

Continued



in the Treatment of Wilms Tumor of Children *J. Urol.* 90:247 (Sept.) 1963.

EFFECT OF NIBBLING *VERSUS* GORGING ON GLUCOSE TOLERANCE

Four subjects were hospitalized on a metabolism ward to study the effects of periodicity of food intake on carbohydrate metabolism as reflected in the oral glucose tolerance test. The study consisted of three periods: (1) baseline, during which a fixed diet was administered as three meals daily; (2) nibbling, during which the identical diet was distributed into 10 equal feedings administered at two-hour intervals over a 19-hour period; and (3) gorging, during which the same diet as in the two previous periods was administered as a single daily meal during one hour in the evening. Each period lasted for at least two weeks, and glucose tolerance tests were performed at the end of each period. Results led to the hypothesis that nibbling produced a normal glucose tolerance test curve, while gorging produced "diabetic" type curves.

Gwinup, G., Byron, R. C., Roush, W. H., Kruger, F., Hamwi, G. J.: Effect of Nibbling Versus Gorging on Glucose Tolerance, *Lancet* (London) 2:165 (July 27) 1963.

SPONTANEOUS LACERATION AND RUPTURE OF THE ESOPHAGUS AND STOMACH

Many patients with hematemesis from laceration of the gastroesophageal junction survive conservative therapy, whereas spontaneous rupture of the esophagus is a surgical emergency with a high mortality rate. Distinction between the two conditions can be made on clinical and radiological grounds. Mediastinal or subcutaneous emphysema and hydropneumothorax serve to distinguish rupture from laceration. Hematemesis from lacerations was first described by Mallory and Weiss, spontaneous rupture by Boerhaave. Use of these eponyms will help avoid confusion between them, for treatment and prognosis are different, despite a common pathogenesis. Spontaneous rupture of the stomach is rare; it can be distinguished from esophageal rupture by evidence of pneumoperitoneum and peritonitis, but it is difficult to distinguish from perforated peptic ulcer, and constitutes a surgical emergency with a high mortality rate. Five cases are presented to illustrate these entities and some of their clinical and pathological variations.

Bruno, M. S., Grier, W. R., Ober, W. B.: Spontaneous Laceration and Rupture of the Esophagus and Stomach, *Arch. Intern. Med.* 112:574 (Oct.) 1963.

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Niacinamide	100 mg.
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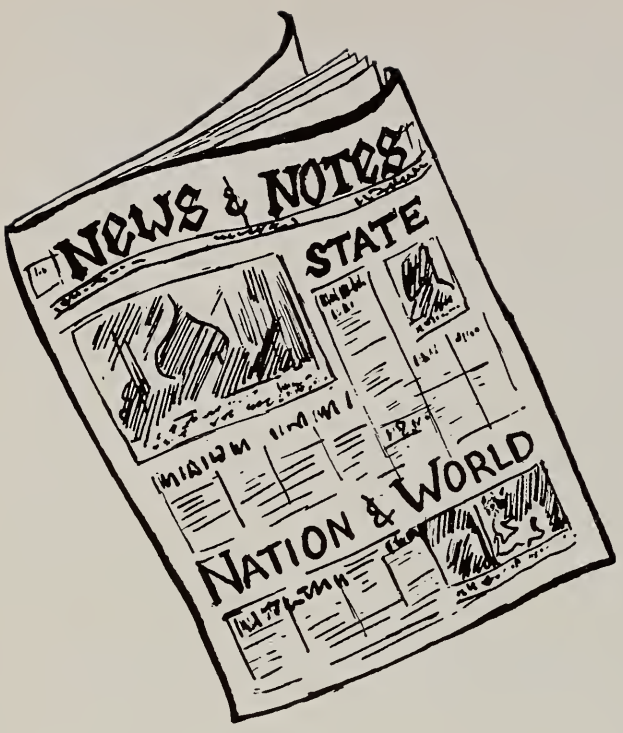
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The person who displays it carries information which should be known to anyone helping him during an accident or sudden illness.

First announced in June, 1963, this symbol is already in such general use that it is essential that it be recognized by all emergency personnel who care for the ill or injured. It means, "Look for medical information that can protect life." Failure to recognize this symbol and to heed its vital message could be disastrous.

Many signal devices of metal or plastic will bear this symbol on one side with a few words of vital information on the other. Other devices will have a pocket within which more detailed information can be found. Still others may consist of the symbol alone—a suggestion to look elsewhere in purse or pocket for important information or identification.

Fix this symbol in your memory—the star of life (or the asterisk of reference), bearing the snake entwined staff of Aesculapius, the mythical Roman god of medicine —taken from the seal of the American Medical Association, and all contained in a hexagon. This symbol may appear in any size or color. It is most likely to be found on the wrist or about the neck, though it may identify the presence of information in other locations. Recognizing it as the universal symbol of emergency medical identification will help you to locate information that may protect life in an emergency.

Dr. Buchanan Elected Chairman

Dr. Wallace D. Buchanan, South Bend, has been elected chairman of the Board of Chancellors of the American College of Radiology. Dr. Buchanan has been a member of the College's Executive Committee and chairman of their Commission on Standards in Radiologic Practice.

AMA Announces $5,000 Medical Journalism Awards Program

The American Medical Association has announced a $5,000 medical journalism awards program "to recognize journalism that contributes to a better public understanding of medicine and health in the United States."

Awards of $1,000 each will be presented for outstanding reporting on health and medicine in five categories—newspapers, magazines, radio, television, and in newspaper editorial writing, said F. J. L. Blasingame, M.D., executive vice president of the AMA.

The awards are intended for recognition of outstanding reporting of the scientific and clinical aspects of medicine. Awards will be presented for the first time in 1965, based on work published or broadcast during the calendar year of 1964.

The awards will *not* be given for work, however excellent, that involves primarily the relaying of medical knowledge to the medical profession and to allied professions. Members of the medical profession, medical associations and their employees are not eligible to submit entries.

Dr. Sputh Named President-Elect

Dr. Carl B. Sputh, Indianapolis, has been

installed as president-elect of the American Rhinologic Society. Dr. H. Ashton Thomas of New Orleans was installed president at recent ceremonies.

Dr. Offutt Elected President

Dr. A. C. Offutt, State Health Commissioner and secretary of the Indiana State Board of Health since 1954, has been elected president of the Association of State and Territorial Health Officers. Dr. Offutt previously served as secretary-treasurer and as vice-president of the organization.

Local Physicians Honored By Internal Medicine Organization

Twelve Indiana physicians have been honored by the American College of Physicians—an national organization representing 12,300 specialists in internal medicine and related fields.

The following physicians were among those designated as Fellows and Associates of the American College of Physicians:

Elected as Fellows were: Drs. J. Hal Doran, Victor C. Hackney, Walter E. Judson, A. Donald Merritt, and Alexander T. Ross, all of Indianapolis; Dr. Jacob Rosenwasser, of Mishawaka; and Dr. Glen A. Ramsdell, of Richmond.

Selected as Associates were: Dr. Louis F. Bradley, of Bluffton; Dr. Thomas E. Vonderhaar, of Evansville; Dr. Jack H. Hall, of Indianapolis; Dr. John L. Frazier, of Kokomo; and Dr. Howard R. Engel, of South Bend.

Dr. Kilgore Opens Office

Dr. Byron Kilgore has opened an office for the practice of psychiatry at 2828 E. State Street, Fort Wayne. Dr. Kilgore addressed the Fort Wayne Psychological Association in December on his findings in a research project begun while he was a Fellow at Menninger's.

American College of Chest Physicians Creates Founder's Lecture

The American College of Chest Physicians has created a "Founder's Lecture" to honor Murray Kornfeld, a layman who founded the society 30 years ago. The lecture is to be presented at each International



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New!—Today's best treatments—ranging from up-dated information on general immunization to newer agents in Rx of meningitis.

BOCKUS—GASTROENTEROLOGY
New (2nd) edition!—An eminent 3-volume work. Covers all known primary and secondary disorders of the digestive tract and its appendages.

REUTER—ATLAS OF UROLOGIC ENDOSCOPY
New!—Explains in word and picture precisely how to use the endoscope.

NEWS NOTES

Continued

Congress of the College, at meetings held every two years. A grant of $1,000 is made to each lecturer for travel and other expenses.

The Eighth International Congress is scheduled for Mexico City, October 11-15, 1964. Mr. Kornfeld is the Executive Director of the College and is Managing Editor of the journal *Diseases of the Chest.*

"Mental Illness in Children" Pamphlet Now Available

"Serious Mental Illness in Children", a 28-page Public Affairs Pamphlet is written to acquaint parents with the present knowledge on childhood schizophrenia. Harry Milt, public relations director for the National Association for Mental Health, is the author.

The pamphlet may be obtained for 25 cents (lower prices for quantities) by writing Public Affairs Committee, 381 Park Ave., South, New York, 10016.

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William A. Ringer, USAF MC FMO, 306 Fortress, KI Sawyer AFB, Mich.

SPECIALISTS

Jack Strom, 3975 Eastway Rd., South Euclid, Ohio —*Anesthesiology*

William G. Ellis, Jr., 13816 Fernwood Ave., Cleveland, Ohio—*Anesthesiology*

William R. Dutchman, 501 Senate Ave., Evansville, Ind.—*Anesthesiology*

Maximilian G. Kaulbach, % 98th General Hospital, APO 34, New York, N. Y.—*Internal Medicine*

Joseph A. Grossman, 1601 Allerton Ave., New York, N. Y.—*Internal Medicine—association with Cardiopulmonary Laboratory*

Robert L. Kent, 1061 Spring Garden Rd., Miami, Fla.—*Ob-Gyn.*

Roger F. Goodspeed, 2914 Griffith, Berkley, Mich. —*Ob-Gyn.*

Paul H. Goldstein, 6143 N. Seeley Ave., Chicago, Ill.—*Ophthalmology*

Robert E. Fechner, 7514 Oxford Dr., Clayton, Mo. —*Pathology-Anatomic*

Thorvald W. Christiansen, 815 Haverford Ave., Pacific Palisades, Calif.—*General and Thoracic Surgery*

Hassan Najafi, 447 West 136th St., Chicago, Ill.— *General and Cardiovascular Surgery.*

LOCATIONS

Gibson County—OWENSVILLE—population 1,100 with a large surrounding territory; mainly farming community. Located 15 miles from Princeton where a new 60-bed hospital is located. Twenty-five miles from Evansville where three hospitals are available. No physician in the community. Office available. Contact Marion E. Warpenburg, D.D.S., Owensville, for further details.



Art, Hobby Show Planned For ISMA Indianapolis Meeting

Space will be provided at the 1964 annual meeting of the Indiana State Medical Association, Oct. 13-15 at Indianapolis, for a Physicians Art and Hobby Show.

Members of ISMA interested in exhibiting pieces and requiring any information regarding this can contact any one of the following:

Dr. Philip T. Holland
108 W. 7th Street
Bloomington

Dr. Charles P. Schneider
2211 W. Franklin St.
Evansville 12

Dr. Truman E. Caylor
303 S. Main St.
Bluffton

Dr. Frank H. Coble
51 S. Eighth Street
Richmond

Dr. Lall G. Montgomery
Ball Memorial Hospital
Muncie

ISMA Headquarters
3935 N. Meridian
Indianapolis 8

It will be the responsibility of each physician to see that his work gets to the exhibition at the Murat Temple. Final arrangements will be taken care of by Dr. Holland and his committee.

The ISMA will provide suitable display facilities, but each physician is responsible for transportation costs and any other such expense involved in entering his exhibit.

Application for Space in Art and Hobby Show Exhibit

Mail to:

Dr. Philip T. Holland
108 W. 7th Street
Bloomington, Indiana

Name_____

Address_____ City_____

Type and number of pieces to be displayed: Photography_____

Sculpture_____

Crafts_____

Painting_____

Other_____

Estimated amount of space required—lineal or square feet_____

Other information_____

FUTURE MEETINGS, SEMINARS, COURSES

VIII International Congress on Diseases of the Chest to Meet

The VIII International Congress on Diseases of the Chest will met in Mexico City, October 11 to 15, 1964.

Address Dr. Miguel Jimenez, Secretary General, Bloque B. Tercer Piso, Mexico, D. F.

Aerospace Medical Association Sets Annual Scientific Meeting

The Aerospace Medical Association will hold its 35th Annual Scientific Meeting at the Americana Hotel in Miami Beach next May 11 to 14. There will be a complete scientific program with 150 scientific and technical exhibits.

Further information may be obtained from Dr. William J. Kennard, Washington National Airport, Washington, D. C.

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American College of Cardiology "Cardiac Arrhythmias" Workshop

The American College of Cardiology will present a workshop program on "Cardiac Arrhythmias" March 4 and 5 in the auditorium of Emerson Hall, I. U. School of Medicine.

The fee for the two-day workshop is $15.00. Further information may be obtained from Philip Reichert, M.D., Empire State Building, New York, N. Y., 10001.

Fractures and Other Trauma Course Scheduled in Chicago

The eighth postgraduate course on Fractures and Other Trauma sponsored by the Chicago Committee on Trauma of the American College of Surgeons will be held on April 22-25, at the John B. Murphy Memorial Auditorium, 50 E. Erie Street, Chicago.

The registration fee is $75.00. Detailed program may be obtained by writing Dr. J. D. Farrington, 55 E. Washington Street, Chicago, 60602.

Ophthalmology, Otolaryngology Meeting Set For April 15-18

The West Virginia Academy of Ophthalmology and Otolaryngology will hold its 17th annual meeting at the Greenbrier Hotel, White Sulphur Springs, West Virginia, on April 15-18.

An outstanding scientific program is planned. A registration fee of $35 for associate members will cover all social and scientific sessions.

A one day contact lens course will be given by Plastic Contact Lens Company. It will be sponsored by the Academy and will be held on Wednesday April 14, prior to the meeting. For additional information, please contact the secretary, Worthy W. McKinney, M.D., Professional Park, Beckley, West Virginia.

Cincinnati Medical Center's 16th Annual Freedman Lectures Set

Dr. Bernard S. Wolf, chairman of the department of radiology of Mount Sinai Hospital and associate clinical professor of radiology at Columbia University, New York City, will present the University of Cincinnati Medical Center's 16th annual Freedman Lectures Saturday and Sunday, April 4 and 5.

Sponsored by the department of radiology in the College of Medicine, the lectures will be given at Cincinnati General Hospital, major teaching hospital in the University's Medical Center.

The lectures are free of charge. Additional information can be obtained from Dr. Jay Crittenden, department of radiology, Cincinnati General Hospital, Cincinnati 29.

Annual Meeting of Wisconsin State Medical Society Scheduled

Dr. David Yi-Yung Hsia, Professor of Pediatrics, Northwestern University School of Medicine will be the guest of the Section on Pathology and Pediatrics at the annual meeting of the State Medical Society of Wisconsin on May 12 in Milwaukee, Wisconsin.

American Ob-Gyn Board Sets Part II Examination

The Part II (oral and clinical examination) for all scheduled candidates is being conducted by the entire board at the Edgewater Beach Hotel, Chicago, Illinois, April 27-May 2.

New and reopened applications and requests for re-examination in 1965 will be accepted in the Office of the Secretary on or before July 1.

As of May 1, 1964, the office of the secretary-treasurer of this board will be located at 100 Meadow Road, Buffalo 16, New York. Dr. Clyde L. Randall replaces Dr. Robert L. Faulkner in assuming the duties of the office.

Sixth Annual "Residents' Day" In Ob-Gyn Scheduled in Detroit

The sixth annual "Residents' Day" in obstetrics-gynecology will be held on March 25th in the auditorium of the Wayne County Medical Society Building, 1010 Antietam St., Detroit.

The subjects to be treated will include the indications for prophylactic oophorectomy; some psychologic aspects of abdominal pain in women (with consideration of polysurgery addiction) ; the problem of urine stress incontinence; the chemotherapy of endometrial and ovarian carcinoma; the failure of establishment of proper respiratory exchange in the immediately newborn infant—causes and treatment; the evaluation of cardiac disease in pregnant women, and indications and contraindications for cardiac surgery in pregnant women; the value of continued follow-up of women treated for gynecologic cancer; and the surgical treatment of cervical and uterine carcinoma.

While this one-day refresher course in "what's new in obstetrics and gynecology" is designed for residents in the specialty, it is also intended for all physicians who practice obstetrics and gynecology; all residents —"current and former", and all interested general practitioners are cordially invited to attend. It is hoped that hospital chiefs-of-service and chiefs-of-staff within traveling distance of Detroit will utilize this educational event by sending their interested residents and interns to this meeting.

Advance registration is requested so that adequate provision for lunch and dinner can be made. Please write to Dr. Charles S. Stevenson, Wayne State University College of Medicine, 1401 Rivard Street, Detroit 7. There is no registration fee for the meeting itself.

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MONTHLY REPORT — December, 1963

Disease	Dec. 1963	Nov. 1963	Oct. 1963	Dec. 1962	Dec. 1961
Animal Bites	339	649	692	397	330
Chickenpox	452	385	107	754	460
Conjunctivitis	49	75	23	103	63
Diphtheria	0	4	1	1	0
Dysentery, Unspecified	65	56	81	65	41
Gonorrhea	293	279	308	Not Available	
Impetigo	54	169	172	88	136
Infectious Hepatitis	48	69	43	71	180
Infectious Mononucleosis	32	38	16	21	17
Influenza	429	566	382	1329	1135
Measles (Rubeola-Rubella)	464	299	123	234	219
Meningitis, Meningococcal	6	2	2	2	2
Meningitis, Other	5	6	8	12	21
Mumps	302	235	139	153	217
Pertussis	6	27	21	68	17
Pneumonia	210	131	87	167	198
Poliomyelitis	0	0	0	3	3
Streptococcal Infections	337	386	291	436	423
Syphilis					
Primary & Secondary	5	5	7	Not Available	
All Other Syphilis	94	120	168	Not Available	
Tinea Capitis	1	14	9	33	20
Tuberculosis (Active)	102	98	111	96	125

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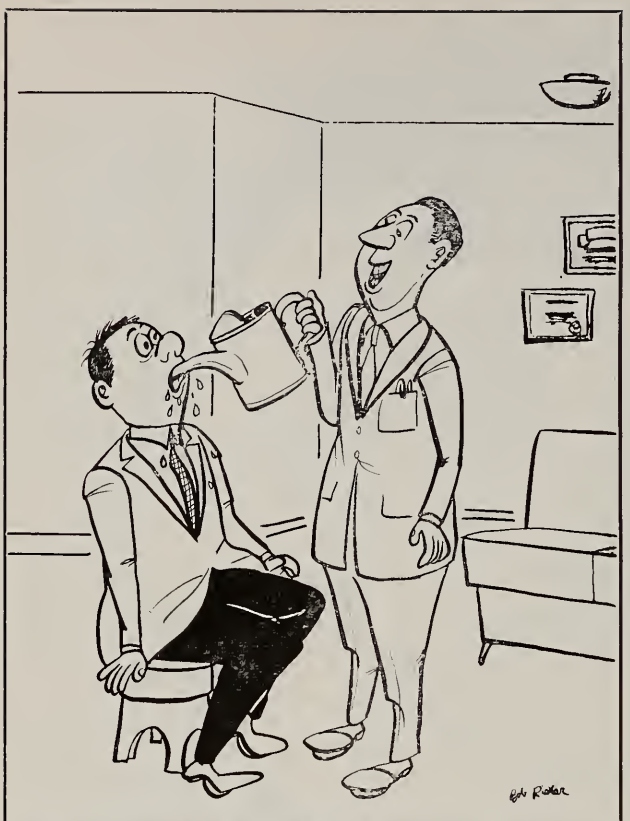
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The Journal Welcomes New ISMA Members

Thomas E. Durham, M.D., *Orthopedic Surgery,* Marquette University, 1958. (Elkhart)

Antonio Hernandez, M.D., *General Practice,* National University, Bogota, Colombia, 1956. (Sullivan)

Wayne L. Knochel, M.D., *General Practice,* Indiana University, 1962. (Fulton)

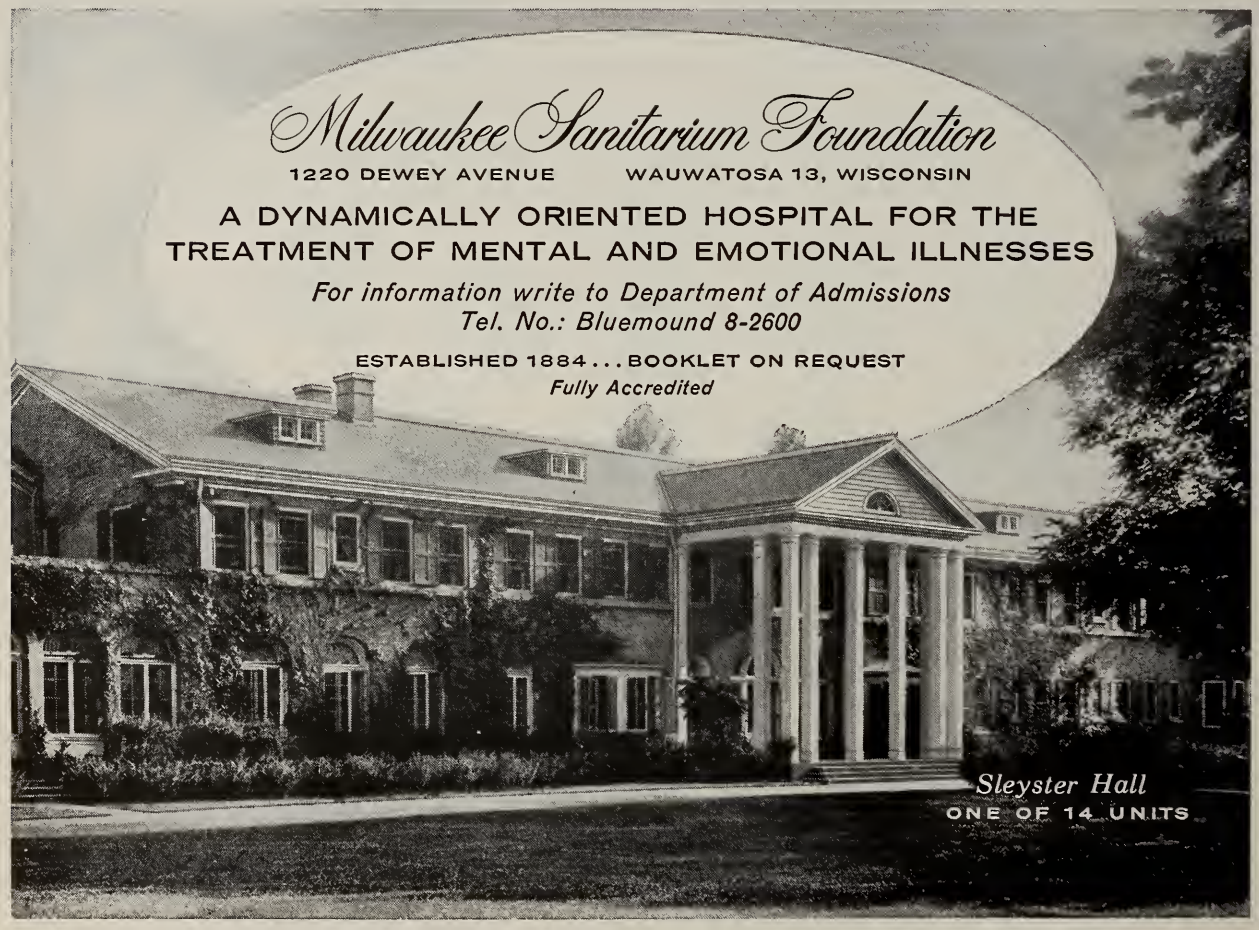
James R. McAfee, M.D., *General Practice,* Indiana University, 1961. (Boone)

Tom G. Sheller, M.D., *Psychiatry,* Indiana University, 1942. (Cass)

David L. Silber, M.D., *Pediatrics,* Vanderbilt University, 1957. (Elkhart)

William A. Stark, M.D., *Orthopedic Surgery,* Temple University, 1953. (LaPorte)

Robert L. Steckbeck, M.D., *Anesthesia,* Loyola University, 1960. (Wells)



County News

Bartholomew-Brown

Dr. Richard O'Bryan has been elected president of the Bartholomew-Brown County Medical Society. Assisting him will be Drs. Floyd Mohler, vice-president and Robert Fuller, secretary-treasurer. Dr. Lindley L. Gammel was elected delegate and Dr. Lowell Beggs, alternate.

Boone

Dr. Clarence G. Kern has been re-elected president of the Boone County Medical Society. Dr. Don W. Boyer was re-elected secretary of the society. Both of the officers are from Lebanon.

Carroll

Drs. George W. Wagoner, Eldon E. Baker and Robert M. Seese have been re-elected president, vice-president and secretary, respectively, of the Carroll County Medical Society. Dr. T. Neal Petry will serve as delegate and Dr. Wagoner as alternate. All of the officers are from Delphi.

Cass

The newly elected president of the Cass County Medical Society is Dr. Lowell J. Hillis. Other new officers include Drs. Francis W. Parker, vice-president; Edward L. TerBush, secretary-treasurer; Earl Bailey, delegate and Donald Winter, alternate.

Clinton

Dr. Albert E. Applegate has been re-elected president of the Clinton County Medical Society. Assisting him will be Drs. H. T. Stout, vice-president and Milton Erdel, secretary-treasurer. Dr. Robert Hedgcock was chosen delegate.

Dearborn-Ohio

Dr. Frank L. Frable, Lawrenceburg is the Dearborn-Ohio County Medical Society's new president; Dr. Edwin L. Gresham, vice-president and Dr. J. Kenneth Jackson, secretary-treasurer. Delegates will be Drs. Leslie M. Baker and Gordon Fessler. Dr. Ivan Lindgren is alternate.

Fayette-Franklin

Drs. George M. Ellis and J. L. Steinem were re-elected president and secretary-treasurer, respectively, of the Fayette-Franklin County Medical Society.

Floyd

New president of the Floyd County Medical Society is Dr. Elmer L. Wallace. Other new officers include Drs. Bogdon Nedelkoff, vice-president; Daniel H. Cannon, secretary-treasurer; Don LaFollette, delegate and Irvin H. Sonne, alternate.

Fountain-Warren

Dr. Edward M. Humphrey has been re-elected president of the Fountain-Warren County Medical Society. Dr. John E. Fisher will be the vice-president and Dr. Peter R. Petrich, secretary-treasurer. Elected delegates were Drs. Petrich and J. W. Crain; alternates are Drs. Lowell Stephens and Carl Nelson.

Hamilton

Newly elected president of the Hamilton County Medical Society is Dr. R. Adrian Lanning. The new vice-president is Dr. Doyle Manhart and the new secretary-treasurer Dr. Eunice M. Carter.

Howard

The Howard County Medical Society elected Dr. Tom W. Wachob as its president for 1964. Dr. R. L. Perkins was elected vice-president and Dr. James Harshman, secretary-treasurer.

Huntington

Elected new officers of the Huntington County Medical Society are: Drs. Paul E. Doermann, president; Joseph Clark, vice-president; Reeve B. Peare, secretary-treasurer; Richard Wagner, delegate and Warren Van Campen, alternate. All of the new officers are from Huntington.

Jay

Installation ceremonies for new officers of the Jay County Medical Society were held Jan. 3 at the Portland Country Club. Installed were: Drs. Forrest E. Keeling, president; Herbert Shroyer, vice-president and C. Franklin Andrews, secretary-treasurer.

Lawrence

Dr. Guy H. Waldo is the new president and Dr. John W. Reuter the new secretary-treasurer of the Lawrence County Medical Society.

Madison

The Madison County Medical Society has elected Dr. James L. Lamey as its 1964 president. Other new officers are: Drs. William K. Patterson, vice-president; David G. Jones, secretary-treasurer; Albert T. Jones, delegate and Robert H. Williams, alternate.

Morgan

The 1964 president of the Morgan County Medical Society is Dr. Robert J. Miller, Paragon. Dr. Jay S. Reese is the new secretary-treasurer, Dr. John Van Wienen, delegate and Dr. Robert E. Brubeck, alternate.

Newton

Dr. Roscoe S. Yegerlehner has been elected president of the Newton County Medical Society. Dr. Arthur Schoonveld has been re-elected secretary-treasurer.

Noble

The Noble County Medical Society has elected Dr. Quentin F. Stultz president; Dr. Robert C. Stone, vice-president; Dr. C. F. Stallman, secretary-treasurer; Dr. Robert Bryan, delegate and Dr. Donald J. Hooker, alternate.

Orange

Re-elected officers of the Orange County Medical Society are Drs. Charles X. McCalla, president; Marion L. Hagan, vice-president and P. T. Hodgin, secretary-treasurer. Dr. Hodgin will serve as delegate and Dr. McCalla as alternate.

Perry

Dr. L. C. Lohoff has been installed president of the Perry County Medical Society. Other new officers are: Drs. Robert G. Gilbert, vice-president; Gene E. Ress, secretary-treasurer; Fred Smith, Jr., delegate and John Mark James, alternate.

Pike

Dr. Milton H. Omstead has been re-elected president and secretary of the Pike County Medical Society.

Rush

Elected new officers of the Rush County Medical Society are: Drs. F. H. Green, president; C. W. Worth, vice-president; M. C. Schneider, secretary-treasurer; Dr. Green, delegate and Dr. S. D. Smith, alternate.

Steuben

Dr. Richard W. Artz has been elected president of the Steuben County Medical Society. Also elected at the December meeting were Drs. Claude Davis, vice-president; John Hartman, secretary-treasurer; Donald Mason, delegate and Don F. Cameron, alternate.

Sullivan

Dr. J. S. Brown, Carlisle, has been elected president and secretary-treasurer of the Sullivan County Medical Society. Dr. Joe E. Dukes will serve as delegate and Dr. R. O. Bethea, alternate.

Tippecanoe

Newly elected officers of the Tippecanoe County Medical Society are: Drs. Robert McAdams, president; Robert C. Bolin, vice-president; George M. Underwood, secretary and Herbert S. Johnson, treasurer.

Wabash

The Wabash County Medical Society has elected the following as new officers: Drs. Paul Eiler, president; C. D. Gatzimos, vice-president; John Dragoo, secretary-treasurer and William Dannacher, delegate.

Wells

Dr. S. Bruce Kephart has been elected president of the Wells County Medical Society. Other new officers include: Drs. John F. Phillips, vice-president; Charles E. Boonstra, secretary-treasurer; Truman E. Caylor, delegate and Dr. Kephart, alternate.

Whitley

The Whitley County Medical Society has elected Dr. Jerome H. Wait president for the coming year. Other officers elected include: Drs. John L. Vogel, vice-president; John Wilson, secretary-treasurer; Thomas G. Hamilton, delegate and Frank M. Thompson, alternate.

Deaths

Irvin C. Barclay, M.D.

Dr. Irvin C. Barclay, Evansville pediatrician for 44 years and past president of the Vanderburgh County Medical Society, died Dec. 10 at Evansville. He was 73.

Before going to Evansville and joining the Baptist Hospital staff as a pediatrician in 1919, Dr. Barclay was an intern at Henry Ford Hospital in Detroit. He also served on the staffs of Deaconess and St. Mary's hospitals at Evansville. Dr. Barclay was a graduate of Johns Hopkins University.

Edgar K. Black, M.D.

Dr. Edgar K. Black, 56-year-old former Wabash physician, died Dec. 12 in a Columbus, Ohio, hospital. Since leaving Wabash in 1957, he had resided at Circleville, Ohio.

Dr. Black practiced in Wabash for 17 years and was a member of the Wabash County Medical Society.

Ralph E. Barnett, M.D.

Dr. Ralph E. Barnett, 54, who practiced medicine for more than 20 years in Peru, died Dec. 19 in Dukes Memorial Hospital.

Dr. Barnett, a former ISMA delegate, began his practice in 1936 after graduation from the I. U. School of Medicine. He interned in Panama and at El Reno, Okla., and served with the Army Medical Corps from 1942 to 1945. He was a member of the Miami County Medical Society.

John C. Davis, M.D.

Dr. John C. Davis, 80, a physician in Logansport for 53 years, died Dec. 24 in his home.

An ISMA Senior Member and member of the 50-Year Club, Dr. Davis was a past president of the staffs of both Logansport hospitals and of the Cass County Medical Society. For almost a half a century, he gave free medical treatment to any high school athlete injured in a game and had delivered from 8,000 to 10,000 babies in his decades as a general practitioner.

Paul R. Tindall, M.D.

Dr. Paul R. Tindall, Shelby County's oldest practicing physician, died Dec. 12 in W. S. Major Hospital. He was 75.

Dr. Tindall had been president of the National Eclectic Medical Association and president of the Shelby County Medical Society. He served 15 years as a member of the Indiana Board of Medical Registration and Examination and was secretary of the board 10 years.

A member of the ISMA 50-Year Club, Dr. Tindall had been an ISMA delegate for 13 years; had served on the Committee on Constitution and Bylaws for two years and had been a member of the Commission on Legislation since 1958.

John A. Tully, M.D.

Dr. John A. Tully, 87, who practiced medicine in New Castle for more than three decades, died Dec. 6 in Henry County Hospital.

Born in a log cabin west of Middletown, Dr. Tully began his practice in Millville in 1901 after graduation from the Kentucky School of Medicine. He was a member of the ISMA 50-Year Club and during World War I received the presidential citation for services on the medical examining board.

Timothy M. Weaver, M.D.

Dr. Timothy M. Weaver, former Clay County coroner, elementary school principal and physician, died Dec. 7 in the Clay County Hospital. He was 92.

A graduate of the University of Illinois School of Medicine, Dr. Weaver had practiced medicine in Staunton, Cory and Brazil and was Brazil's city health officer for several years. He was Clay County coroner two terms and served five terms as president of the Clay County Medical Society.

Association News

EXECUTIVE COMMITTEE

December 1 1963

Present: Ralph V. Everly, M.D., chairman; George Willison, M.D.; Don E. Wood, M.D.; Joe M. Black, M.D.; K. O. Neumann, M.D.; Irvin W. Wilkens, M.D.; and James A. Waggener, executive secretary.

Also present were the following delegates and alternate delegates: Harold C. Ochsner, M.D.; E. S. Jones, M.D.; Guy Owsley, M.D.; Jack E. Shields, M.D.; Robert M. Brown, M.D.; Frank Green, M.D.; William B. Challman, M.D.; and John M. Paris, M.D.

In addition, the following guests were in attendance: Lester D. Bibler, M.D., trustee of the AMA; Lall G. Montgomery, M.D.; delegate, Section on Pathology; and Mr. Arthur G. Loftin, secretary of the Marion County Medical Society.

AMA Matters

The first order of business was a discussion of a letter from the AMA concerning hearings by the Committee on Reorganization of the House of Delegates of the AMA.

Next the resolutions, referred to the AMA by the Indiana State Medical Association were reviewed and discussed.

Letters of intention to nominate Dr. Ray McKeown of Coos Bay, Oregon, president-elect of the AMA were read for information of the committee, as well as a letter indicating the recommendation for the nomination of Dr. Donovan Ward as president-elect of the AMA.

The committee then reviewed the resolutions which were to come before the AMA House of Delegates.

The next item of business was the election of a chairman of the delegation and the floor leader for the delegation. Upon motion of Drs. Shields and Owsley, Dr. Wood was elected chairman of the delegation and Dr. E. S. Jones was elected floor leader. Dr. Neumann then moved the nominations be closed and a unanimous ballot be cast; seconded by many and carried.

The president then recommended the following assignments to the various reference committees:

Amendments to Constitution and Bylaws, Drs. Owsley and Brown.

Reports, Board of Trustees, Drs. Shields and Wilkens.

Insurance and Medical Service, Drs. Neumann and Paris.

Legislation and Public Relations, Drs. Black and Green.

Medical Education and Hospitals, Drs. Ochsner and Land.

Miscellaneous Business, Drs. Everly and Challman.

Public Health and Occupational Health, Drs. Jones and Willison.

Upon motion by Drs. Neumann and Ochsner, the recommendations of the president were adopted.

It was decided that the delegates would caucus fifteen minutes after adjournment of the House of Delegates on Monday. Also the breakfast meetings for Monday and Tuesday mornings would be cancelled with the delegates meeting for breakfast at 7:30 a.m. in Parlor E of the Hilton Hotel Wednesday morning.

At this time the delegates, alternate delegates and guests were excused and the committee took up its regular business.

Minutes of the meeting of October 14, 1963 were adopted on motion of Drs. Wilkens and Neumann.

Membership Report:

Number of members as of December 31, 1962		4,340
1963 members as of October 31, 1963:		
Full dues paying	3,764	
Residents and interns	144	
Council remitted	44	
Senior	338	
Honorary	3	
Military	57	
Total 1963 members as of October 31, 1963		4,350
Number of members as of October 31, 1962		4,323
Gain over last year		27
Number of AMA members as of October 31, 1963		4,239
Total 1962 AMA members as of September 30, 1962		4,198
Gain over last year		41
1963 AMA members: Dues paying	3,651	
Exempt, but active	588	
		4,239
Number who have paid state dues but not AMA dues as of October 31, 1963		111

Headquarters Office

The secretary recommended that the association take a membership, at a cost of $25.00, in the Professional Convention Management Association. This was approved on motion of Drs. Wilkens and Wood.

The secretary reported on the tax situation as far as the association is concerned in dealing with purchases under the new Sales Tax Law. He reported that in several discussions with legal counsel, it was felt at this time that the association, while being a non-profit organization and being exempt from Federal and Gross Income taxes, would be required to pay the 2% sales tax on supplies purchased by the association.

Building Matters

The chairman of the Building Committee reported the committee had purchased a new refrigerator for the proposed new warming kitchen in the association headquarters building.

Dr. Willison inquired about the use of the building by other groups, such as the Indiana Chapter of Internal Medicine, and he was informed that the association's position is that medical specialty groups would be welcome to use the building, pointing out that if the building is used during regular office hours there will be no charge, but if it is necessary to open the building solely for the benefit of a group, the group would be expected to pay a nominal charge for personnel which would be necessary to be in attendance and, of course, for any food consumed.

Dr. Wood again raised the question about humidification of the building, pointing out that in his opinion, lack of proper humidity in the building was injurious to the furniture, aggravated colds among the employees, and in all probability made the heating expense higher than if proper humidity controls were installed.

Following a discussion of this matter, the secretary was instructed to obtain complete information concerning the cost of a humidifying system and an estimate projecting the savings, if any, on heating and air conditioning by virtue of having the building humidified.

Treasurer's Office

The treasurer reported on the cash balances.

Annual Convention, Indianapolis October 13, 14, and 15, 1964:

The report of the Convention Arrangements Committee for the 1964 session was presented, there being several changes in format recommended by the commission. Upon motion of Drs. Wood and Neumann, the Executive Committee adopted the report in principle and the report was referred to the Council for discussion and action at its January meeting.

A letter from Dr. Jack Hall of Methodist Hospital was read clarifying the misunderstanding that seemed to exist as a result of the effort of Methodist Hospital to run a scientific program at the same time as the 1963 annual convention. No action was taken.

Report submitted by Smith Kline & French indicating the attendance at the TV programs by the hour was read for the information of the committee.

Organization Matters

Actions of House of Delegates:

1. The president announced that in accordance with the action of the House of Delegates, he had appointed a planning committee composed of Dr. Glock, as chairman, and Drs. M. C. Topping, Peter Petrich, Albert Donato and Herman C. Echsner. The appointment of these members was approved on motion of Drs. Black and Wilkens.

2. Resolution No. 1, as adopted by the ISMA House of Delegates was reviewed, calling for the ISMA to provide needed leadership in improving patient care programs and other activities. On motion of Drs. Wood and Neumann, this resolution is to be referred to the Commission on Medical Education and Licensure, as a part of the business of this commission, with the recommendation that the commission consult with the Joint Council to Improve Patient Care.

3. The report of the Reference Committee on Insurance, in which it was recommended that consideration be given by the appropriate commission to the development of an Impartial Medical Witness program was discussed. On motion of Dr. Black, taken by consent, the President is to review this matter and make the assignment to the appropriate commission.

A letter from the AMA recommending that the ISMA, or a physician member, play the role of host to a meeting of industrialists and business leaders of the community for the purpose of encouraging them to contribute to the AMA-ERF program was discussed. Upon motion by Drs. Wood and Willison, this matter was referred to the Student Loan Committee for study and consideration.

The secretary read acknowledgments from members of Congress concerning the resolution on narcotic addiction which was introduced and adopted by the House of Delegates at the October meeting.

Several letters of acknowledgment were read from organizations whom the association had written complimenting them in the role they played in the Coliseum disaster.

A letter from the Joint Committee on the Improvement of Patient Care in Indiana informing the association that the terms of office of Dr. John Davis and Dr. Jack Eisaman would expire as of December 31 was read, and by consent it was agreed to reappoint both of these men.

Requests from the Indiana Academy of General Practice and the Indiana Heart Association for use of the association mailing list were approved.

A request of the Indiana Department of Conservation for the use of the mailing list of the association for the purpose of distributing "Outdoor Indiana" to the physicians of Indiana was approved and the secretary was instructed to notify the department that this approval would hold until further notice.

A letter from Lieutenant Elmer C. Paul expressing his pleasure for the action taken by the association in recognition of the part he played in originating the auto crash injury program was read for the information of the committee.

A request from the Better Business Bureau for a dues increase of $50.00, making the total dues $200.00 rather than $150.00, as in the past, was approved on motion by Drs. Wood and Wilkens.

Further correspondence concerning the action previously taken by the committee concerning the Indiana Institute of Medical Assistants was read for the information of the committee.

A statement in the amount of $25.00 for the annual contribution to the Indiana Joint Council to Improve the Health Care of the Aged was approved for payment on motion of Dr. Willison, taken by consent.

Future Meetings

January 29-30, U. S. Chamber of Commerce Public Affairs Conference. It was agreed that no representative would be sent to this conference.

March 6-7, AMA National Conference on Rural Health. Permission was given to Dr. Rifner, or someone selected by him, to attend this national conference.

March 9-11, National Health Forum, Pittsburgh. It was determined no representative would be sent to this meeting.

April 16-18, AMA Biennial Legal Conference in Chicago. The committee authorized the attendance at this conference by the legal counsel of the association.

The secretary reported that he had tentatively made plans for the annual dinner for the Indiana delegation in Washington, D. C. on Monday night, April 27, 1964. This action was approved by consent.

There being no further business, the Executive Committee adjourned to meet again on Saturday, January 11, 1964, at 2:00 p.m. at the headquarters office building.

EXECUTIVE COMMITTEE

December 4, 1963

The Executive Committee of the Indiana State Medical Association met in Parlor E of the Portland Hilton Hotel, Portland, Oregon, at 7:30 a.m. on December 4, 1963, with the following members present: Ralph V. Everly, M.D., chairman; George Willison, M.D.; Don E. Wood, M.D.; J. M. Black, M.D.; K. O. Neumann, M.D.; Irvin W. Wilkens, M.D.; and James A. Waggener, Executive Secretary.

Delegates and alternate delegates: Harold C. Ochsner, M.D.; E. S. Jones, M.D.; Francis L. Land, M.D.; Guy Owsley, M.D.; Jack Shields, M.D.; Robert M. Brown, M.D.; Frank Green, M.D.; William Challman, M.D.; and John Paris, M.D.

Guests: Lester D. Bibler, M.D., AMA trustee; Lall G. Montgomery, M.D., delegate, Section on Pathology; and Arthur G. Loftin, Executive Secretary, Marion County Medical Society.

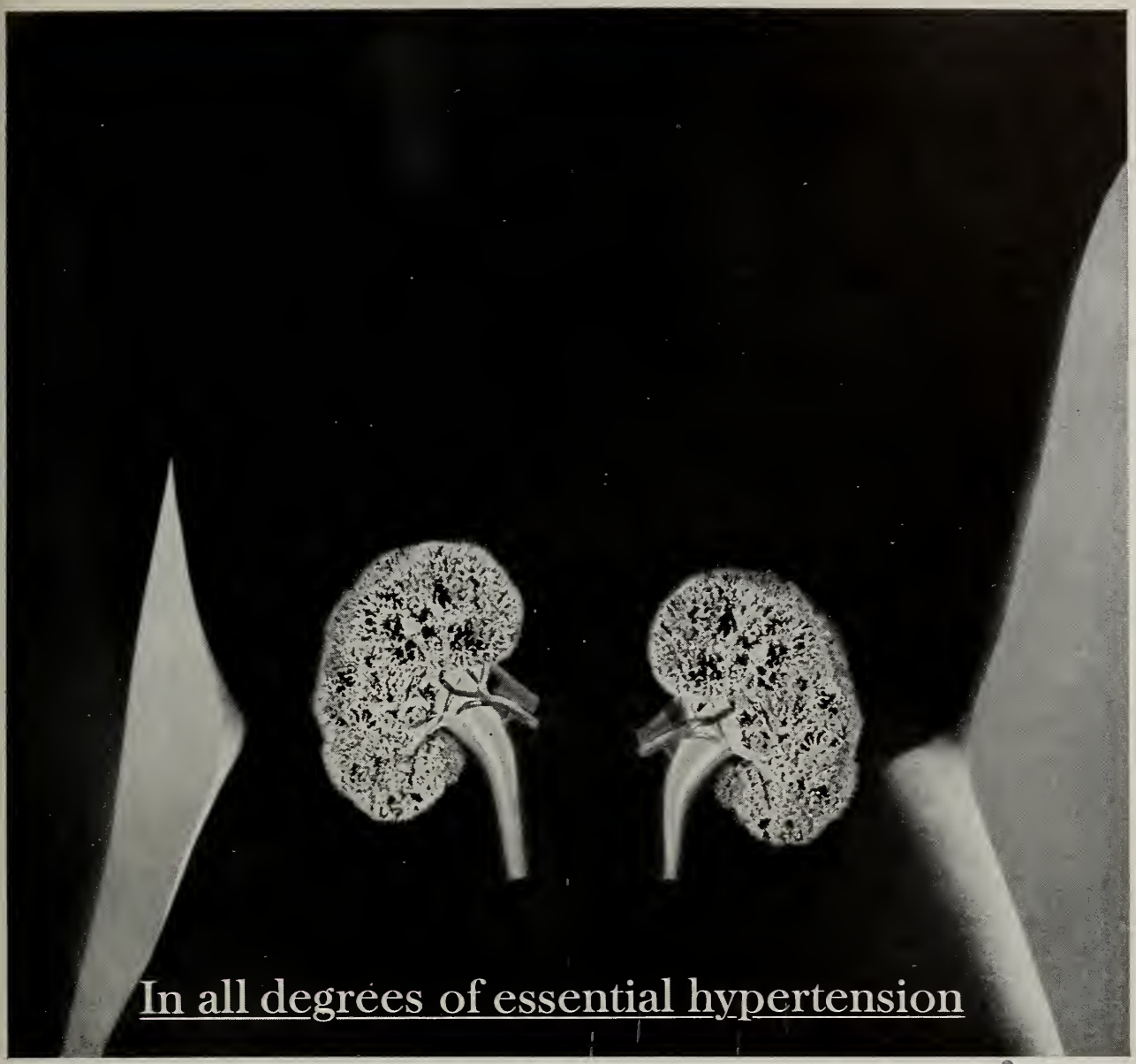
AMA Matters

The delegates reported on the actions and discussions which took place before the various reference committees and upon motion of Drs. Owsley and Ochsner, it was moved that the officers of the association express their appreciation to the Womans' Auxiliary of the ISMA for being the fourth in the nation in contributions to the AMA-ERF program. The motion was carried unanimously.

Organization Matters

Upon motion of Drs. Neumann and Black, it was agreed that the employees of the Indiana State Medical Association are to receive the equivalent of a week's salary as a Christmas gift.

There being no further business the committee adjourned.



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References: (1) Moyer, J. H., and Heider, C.: Am. J. Cardiol. *9*:920 (June) 1962. (2) Brest, A. N., and Moyer, J. H.: Pennsylvania M. J. *63*:545 (Apr.) 1960. (3) Berry, R. L., and Bray, H. P.: J. Am. Geriatrics Soc. *10*:516 (June) 1962. (4) Hutchison, J. C.: Current Therap. Res. *4*:610 (Dec.) 1962. (5) Feldman, L. H.: North Carolina M. J.: *23*:248 (June) 1962.

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March 1964

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

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EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members. Cost of color illustrations must be shared by the author.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible. However, the right is reserved to reduce in length or reject any article.

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About Our Cover by Robert W. Harger, M.D., on page 236.



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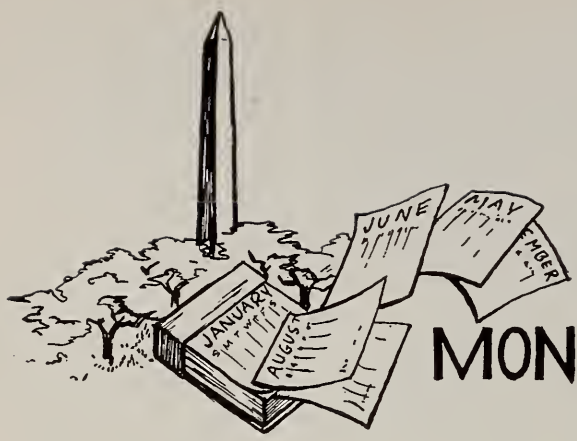
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This summary of what is happening in Washington is prepared by A.M.A.'s Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

MONTH IN WASHINGTON

WASHINGTON, D. C.—A finding by a special Federal government committee of physician and scientist experts that cigarette smoking is a serious health hazard gave impetus to further research with the objectives of determining the harmful factors in smoking and eliminating them.

The House of Delegates of the American Medical Association had authorized a basic research program into smoking and health before the special committee's report was made public in January. The House Agriculture Committee approved legislation authorizing a Federal research program into how to make cigarettes safe. The Johnson Administration included in its fiscal 1964-'65 budget an appropriation request for $5 million for research on smoking.

The 10-member Advisory Committee to the Surgeon General of the Public Health Service reached the unanimous conclusions that:

"Cigarette smoking is a health hazard of sufficient importance in the United States to warrant appropriate remedial action. . . .

"In view of the continuing and mounting evidence from many sources, it is the judgment of the committee that cigarette smoking contributes substantially to mortality from certain specific diseases and to the overall death rate. . . .

"Cigarette smoking is causally related to lung cancer in men: the magnitude of the effect of cigarette smoking far outweighs all other factors. The data for women, though less extensive, point in the same direction."

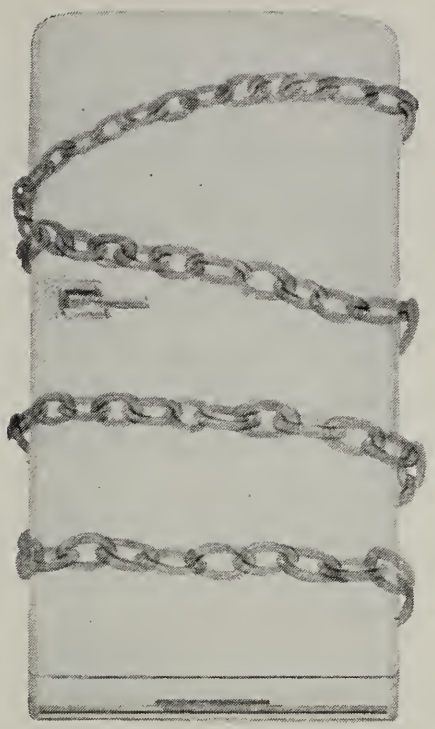
Dr. Edward R. Annis, president of the American Medical Association, urged "the American people to give careful and thoughtful attention to this report and to the strong evidence linking smoking to cancer and other diseases."

"It should be noted that the report indicates that further research could be valuable and, in this connection, Surgeon General Luther L. Terry expressed approval of the American Medical Association's comprehensive, long-range program of basic research on tobacco and health, which was announced last December," Dr. Annis said.

"Despite the strong evidence against smoking which has been amassed in this report, it is unrealistic to assume that the American people are suddenly going to quit smoking. Because people will continue to smoke, research efforts should try to find how tobacco smoke affects health and, if possible, to eliminate whatever element in the smoke that may induce disease.

"This is what we hope to do through the AMA research project on tobacco

Continued



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Side effects: Insomnia may occur if taken later than 6 hours before retiring. The usual peripheral actions of sympathomimetic amines (vasoconstriction and acceleration of the heart) are minimal and little noticed on low or moderate dosage.

Contraindications and precautions: Should not be used in patients with myocardial degeneration, coronary disease, marked hypertension, hyperthyroidism, insomnia or a sensitivity to ephedrine-like drugs. Moderate hypertension in the obese is not necessarily a contraindication since it may be relieved as the overweight is reduced.

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and health."

DR. HICKAM NAMED TO AMA-ERF COMMITTEE

Three members of the Surgeon General's Advisory Committee were named to the five-member committee that will direct the American Medical Association Education and Research Foundation's long-range program of research on tobacco and health. They are:

Maurice H. Seevers, M.D., Ph.D., chairman of the Department of Pharmacology at the University of Michigan Medical School and named chairman of the AMA-ERF committee; John B. Hickam, M.D., chairman of the Department of Internal Medicine at the University of Indiana Medical School, and Charles LeMaistre, M.D., professor of internal medicine, Southwestern Medical School.

The other two members of the AMA-ERF committee are Paul S. Larson, Ph.D., chairman of the Department of Pharmacology at the Medical College of Virginia, and Richard J. Bing, M.D., chairman of the Department of Medicine, Wayne State University College of Medicine.

The AMA Board of Trustees made an initial appropriation of $500,000 for the research program, and announced contributions would be accepted from other foundations, industry, voluntary health associations, physicians and other sources—but only if given without restrictions.

On the clear understanding that there were absolutely no restrictions attached, a contribution of $10 million was accepted from six tobacco companies. These funds will be made available over a five-year period as needed.

The first remedial action advanced by the Federal government was new cigarette advertising regulations proposed by the Federal Trade Commission. The rules, subject to modification after open hearings in March, would require that in all cigarette advertising or labeling:

There be a clear warning that cigarette smoking may cause death; there be no implication that cigarette smoking promotes good health or physical well-being, and there be no claim that smoking one brand is less harmful than smoking another. The Federal government banned the distribution of free cigarettes in Public Health Service, military, Indian and Veterans Administration hospitals. The government also launched educational campaigns pointing out the hazards of smoking to patients in the hospitals.

Highlights of the advisory committee report included:

Cancer by Site

Lung Cancer: "The risk of developing lung cancer increases with duration of smoking and the number of cigarettes smoked per day, and is diminished by discontinuing smoking.

"The risk of developing cancer of the lung for the combined group of pipe smokers, cigar smokers, and pipe and cigar smokers, is greater than for non-smokers, but much less than for cigarette smokers."

Oral Cancer: "The causal relationship of the smoking of pipes to the development of cancer of the lip appears to be established."

Cancer of the Larynx: "Evaluation of the evidence leads to the judgment that cigarette smoking is a significant factor in the causation of laryngeal cancer in the male."

Non-neoplastic Respiratory Diseases, Particularly Chronic Bronchitis and Pulmonary Emphysema

"Cigarette smoking is the most important of the causes of chronic bronchitis in the United States, and increases the risk of dying from chronic bronchitis. . . .

"For the bulk of the population of the United States, the importance of cigarette smoking as a cause of chronic bronchopulmonary disease is much greater than that of atmospheric pollution or occupational exposures. . . .

"Cigarette smoking does not appear to cause asthma."

Cardiovascular Disease

"Smoking and nicotine administration cause acute cardiovascular effects similar to those induced by stimulation of the autonomic nervous system, but these effects do not account well for the observed association between cigarette smoking and coronary disease. . . . It is more prudent to assume that the established association between cigarette smoking and coronary disease has causative meaning than to suspend judgment until no uncertainty remains."

Maternal Smoking and Infant Birth Weight

"Women who smoke cigarettes during pregnancy tend to have babies of lower birth weight.

"Information is lacking on the mechanism by which this decrease in birth weight is produced.

"It is not known whether this decrease in birth weight has any influence on the biological fitness of the newborn." ◄

A Counterblast to Tobacco*

"A custom loathsome to the eye, harmful to the brain, dangerous to the lungs and in the black, stinking fume thereof, nearest resembling the horrible Stygian smoke of the pit that is bottomless. Herein is not only a great vanity, but a great contempt of God's good gifts; that the sweetness of man's breath, being a good gift of God, should be willfully corrupted by this stinking smoke."—James I of England (1566-1625).

* Written in 1604.



LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

NOW AND THEN

He Combined Pills, Companionship

By Griff Niblack

Doctors are fine people and are among our leading citizens. It would be nice to get to know one of them someday and find out a little more about the modern M.D.

The general impression gained by the average individual who is not very sick but has what he thinks are mysterious aches and pains is pretty blurry. He's in and out of his doctor's office so fast about the only communication he has with his doctor is to stick out his tongue and say, "Aaaagh."

Sometimes it all happens so fast the patient is not quite sure he has been there at all. Usually he is reassured as to this point by glancing at the little piece of scribbled paper he finds himself holding. It's a prescription which any drugstore will be glad to fill for a pretty penny.

The modern doctor, of course, is not to blame for what seems to be unseemly haste. His office is usually filled to standing room only with other groaners and there are only so many hours in a day. We suppose a doctor, too, has to eat and sleep and maybe say an occasional hello to his family.

This is not to criticize the modern man of medicine who, with the aid of miracle drugs, does a rather monumental job of keeping us alive and kicking. But in retrospect, it appears that being sick in the good old days was more fun than it is now.

Certainly, it was more chummy.

The old time family practitioner somehow had more time available for his patient. Maybe the days were longer then. Everything else has changed, so maybe the time system has, too.

What ever the reason, he always found a few extra moments to spend with the patient whether in his office or at home. Nor was it absolutely necessary for the patient to be seriously ill before he made a house call.

We remember one G.P., a rather portly, dignified gentleman with a bristling white moustache which gave him a forbidding appearance. We knew better, though. Twinkling blue eyes revealed the humor and understanding that lay beneath the solemn exterior.

He'd sit beside the bed and listen patiently to the catalogue of complaints. Then he'd thrust a thermometer in your mouth and take your pulse, meanwhile making withering comments about the way you did, or did not, take care of yourself.

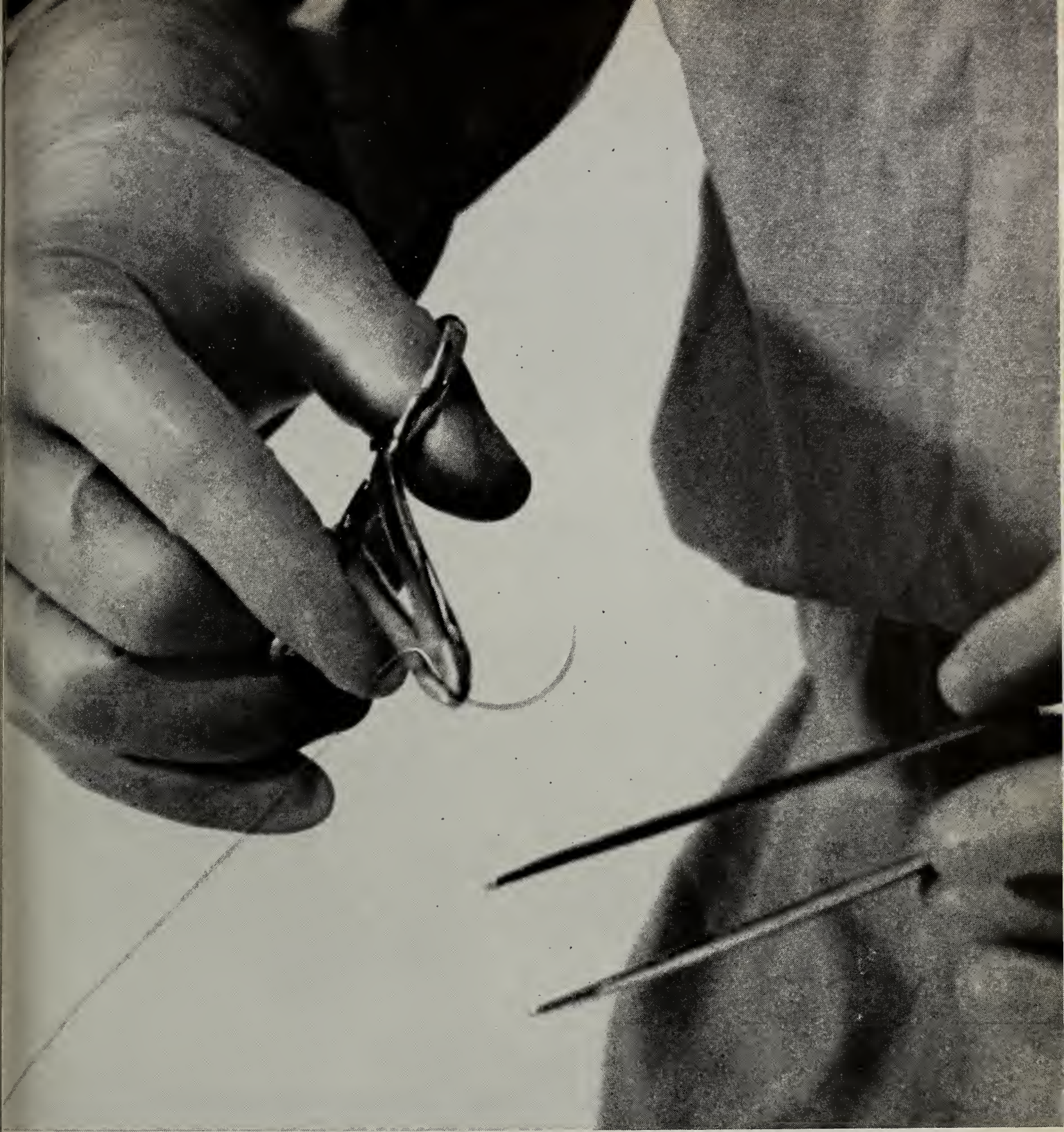
Dipping into his beat-up black bag, he'd bring out a bottle of nauseous looking pink pills, advise you to drop in and see him in a few days, put on his crumpled hat and leave. He never sent any bills so you never were sure how much a house call was.

Whatever it was, the patient always felt better, possibly because of the psychological lift that resulted from his taking time to listen.

A call at his office was scarcely designed to make one feel better. It was a dingy place at best, and with its dirty windows, with its stacks of old newspapers and magazines, the office by no stretch of the imagination could be defined as antiseptic. But when the doctor was there in leisure moments, it was filled with witty conversation.

The patients were bothered by neither the

Continued



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rumpled doctor nor the disheveled office. They said that Old Doc knows what he is doing. He's pretty good.

If one were forced to choose between the modern, streamlined, antiseptic treatment, with its miracle drugs, and the old general practitioner with his musty office, there is little doubt which choice he would make.

But that doesn't keep a fellow from wishing that the modern technic and the outmoded close personal relationship could coexist.—*Indianapolis News,* Dec. 17, 1963.

Medical Situation

A new development in hospitals is the extent to which they are replacing the family physician. The emergency ward is occupying a more and more important place in hospital service.

This has come about, in part, because of the difficulty of getting hold of a doctor without going to his office. House calls, at least in populous areas, form a decidedly lesser part of the average physician's practice. When Johnny puts his hand through a windowpane, or mother feels an unexpected pain, the hospital emergency ward often becomes their destination. There a doctor is on duty 24 hours a day.

Hospitals are increasingly handling this situation by letting physicians not on the staff have offices in the hospital. One result of this is that the patient must not only pay the hospital but must also pay the doctor's fee just as if there had been a visit to his office. This is fair enough, from the doctor's standpoint, but sometimes patients find the practice irritating.

The basic difficulty is the shortage of doctors, and especially of general practitioners. More and more specialists are being turned out, and there is growing emphasis on research. Obviously, research is important. Just as obviously — though less so, it would seem, to the medical schools — an adequate number of general practitioners is of vital importance. The situation calls for reexamination without prejudice by hospitals, medical schools and the medical profession generally. — *Evansville Courier,* Dec. 19, 1963.

New Major Hospital

Construction of a new 600-bed public medical center on the expanded site of the Memorial Clinic at 3202 N. Meridian will help Indianapolis keep pace with its increasing hospital needs in relation to its greater population.

Combined with new facilities planned and presently under construction by existing hospitals, this major addition should be welcomed by all our citizens. The prospective importance of the Winona Memorial Hospital, as the new N. Meridian center will be known, may be realized in the announcement that it will cover much of a whole block. It will consist of an eight-story general hospital, a professional building for doctors and laboratories, a nursing home, an underground parking garage and a patient self-care unit. It will be a complex of buildings with functions closely related. It will be a great new asset to Greater Indianapolis.

Other hospital expansions here include the planned new Krannert Tower at Methodist, planned new construction at General, the ultra-modern "silo" wing nearing completion at Community, the optioning of a site on West 86th Street for an entirely new St. Vincent's, and the new University Heights Hospital.

Added to these, the $20 million privately financed Winona Hospital will go far toward assuring that adequate bed healing facilities and medical technics will be available to our people for the city's foreseeable future.—*Indianapolis News,* Dec. 12, 1963. ◄

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Supervised by THE COUNCIL

Volume 57 — March 1964 — Number 3

Treatment of Arrhythmias by Use of Synchronized Direct Current Countershock

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THE NEED FOR a rapid, safe, easily administered method to terminate ectopic rhythms is obvious. The current medical management, using potentially toxic drugs in gradually increasing dosages, is time consuming and occasionally without the desired result. With the advent of closed chest cardiac massage[1] to overcome ventricular tachycardia or fibrillation, there has been renewed interest in finding the most effective forms of electrical countershock.

Lown et al.[2] have described a new method using direct current countershock synchronized to the electrocardiograph. The shock is delivered during the nonvulnerable phase of repolarization. In animal studies[3], this method has proven efficient and safe enough to suggest its use for most forms of ectopic rhythms. Lown[4] and Killip[5] have reported on the clinical use of this method. The purpose of this paper is to report our experience with this method in 39 attempted countershocks and show illustrative cases.

* From the Krannert Heart Research Institute, Marion County General Hospital, the Department of Medicine and Heart Research Center, Indiana University School of Medicine, Indianapolis. Supported by the Herman C. Krannert Fund, the Indiana Heart Association, Indiana State Board of Health and (in part) by the U.S. Public Health Service Training Grant 5363 and (in part) with facilities provided by Cardiovascular Clinical Research Center Grant H-6308 from the National Heart Institute, National Institutes of Health, U. S. Public Health Service.

Method

Countershock was performed in the surgery recovery room. Methohexital sodium (Brevital) was administered intravenously by an anesthetist until amnesia was achieved. All patients had received conventional drug therapy initially unless the arrhythmia was such as to cause impending vascular collapse. When possible the subject was in the fasting state. Oral anticoagulant therapy was used only in cases where there was a history of embolism. Quinidine 1.2 gms daily was given 24 hours prior to conversion when time permitted, otherwise it was started as soon as the patient was selected for cardioversion.

An American Optical Company cardioverter was used. One paddle was placed at the second interspace, right sternal border, and the other at the apex. Synchronization of the impulse to the patient's recorded electrocardiogram was tested by discharging the machine with the paddles approximated. The cardioverter was synchronized to deliver the impulse at zero time with respect to the peak of the R wave. There is approximately an 0.1 second delay after the peak of the R wave inherent

in the electronic unit. The initial energy used was 100 watt/second, being increased by 50 watt/second when subsequent shocks were necessary. The patients were observed for one hour and returned to their beds, being allowed up when fully recovered from the anesthesia. The countershock procedure requires approximately 15 to 20 minutes. Patients are maintained on quinidine 1.2 gm daily in divided doses.

Case 1. A 39-year-old colored male had a myocardial infarction in 1962. On 8-30-63 he was seen in the emergency room because of chest pain with increasing dyspnea of 12 hours duration. On admission the patient was apprehensive and dyspneic, with a blood pressure of 120/80 which fell to 90/60. Because of the nature of his cardiac rhythm (Figure 1) and vascular collapse, he was taken to the recovery room, given Brevital intravenously and received one countershock of 100 watt/second. Sinus rhythm was established with immediate restoration of normal blood pressure. The patient was observed for 14 days during which time there was no recurrence of the tachycardia or evidence of acute myocardial infarction. The patient was discharged and followed as an out-patient on 1.2 gm quinidine. He has remained in sinus rhythm.

Comment: Because of the impending vascular collapse, drug therapy of necessity would have had to be by vein, carrying an increased risk especially in the presence of coronary artery disease. Cardioversion was completed within 30 minutes of admission to the hospital.

Case 2. A 64-year-old white male was admitted for treatment of atrial tachycardia. Increasing exertional dyspnea had caused

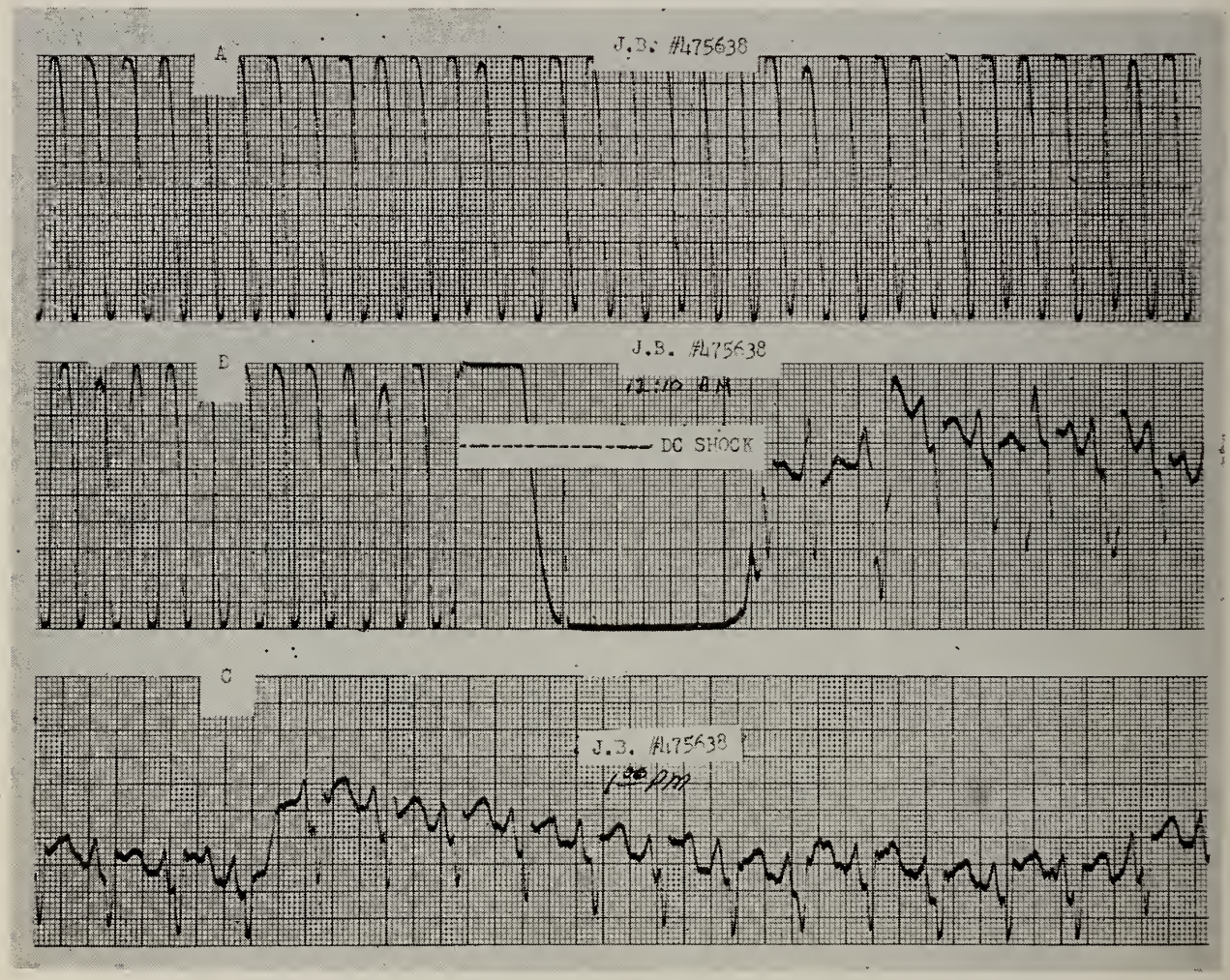


FIGURE 1

(a). PRE-SHOCK electrocardiogram, systolic blood pressure at this time was 80 mm of Hg. The rate suggests supraventricular tachycardia with aberrant conduction. (b). Continuous ecording during D.C. shock. Showing a 2.20 second delay before first QRS. (c.) Post-shock electrocardiogram. This tracing corresponded to a lead II recorded at a previous admission.

him to seek medical attention. Conversion was attempted first with digitalis 1.4 mgm, quinidine was added but discontinued due to gastrointestinal toxicity while receiving 2.0 gm daily. The patient was maintained on digitoxin 0.1 mgm and quinidine 1.2 gm daily. Direct current shock (Figure 2) consisted of one 100 watt/second stimulus with immediate restoration of sinus rhythm. He has been followed since 9-9-63 during which time sinus rhythm has persisted. He has noted an increase in exercise tolerance.

Comment: Titration of various cardiac drugs required hospitalization for five days during which time no conversion was effected. The immediate response to cardioversion suggests that if more vigorous treatment is not effective in 24 to 48 hours, cardioversion should be considered.

Case 3. A 24-year-old white male with known tight mitral stenosis had recently developed auricular fibrillation. Four weeks prior to mitral valvulotomy, he developed left upper quadrant pain suggestive of embolic phenomena but was thought to have acute pyelonephritis. At the time of surgery, clots were present in the left atrium. Postoperatively oral anticoagulants were started as soon as feasible. The patient received one shock of 100 watt/second, on the seventh postoperative day (Figure 3). After returning to the ward, anticoagulants were gradually withdrawn. The patient has been followed since 8-20-63. He remains in sinus rhythm, is gaining weight and has returned to work.

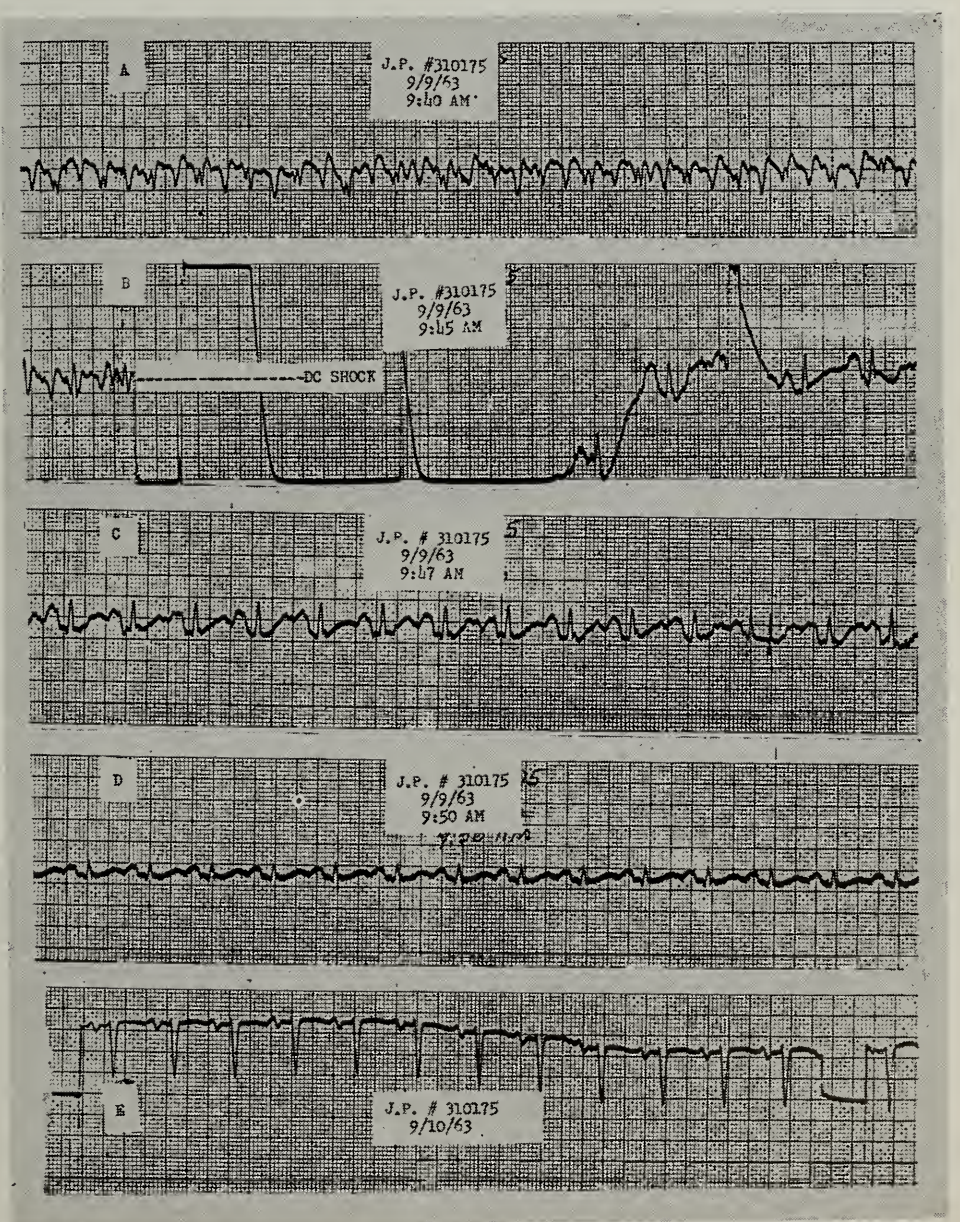


FIGURE 2
(a.) CONTROL ELECTROCARDIOGRAM after digitalis and quinidine therapy. (b.) Continuous recording during direct current shock. 4.20 seconds elapsed between shock and first QRS complex. (c.) Post-shock recording through cardioverter monitor. (d. and e.) Electrocardiogram recorded in conventional manner using Sanborn equipment.

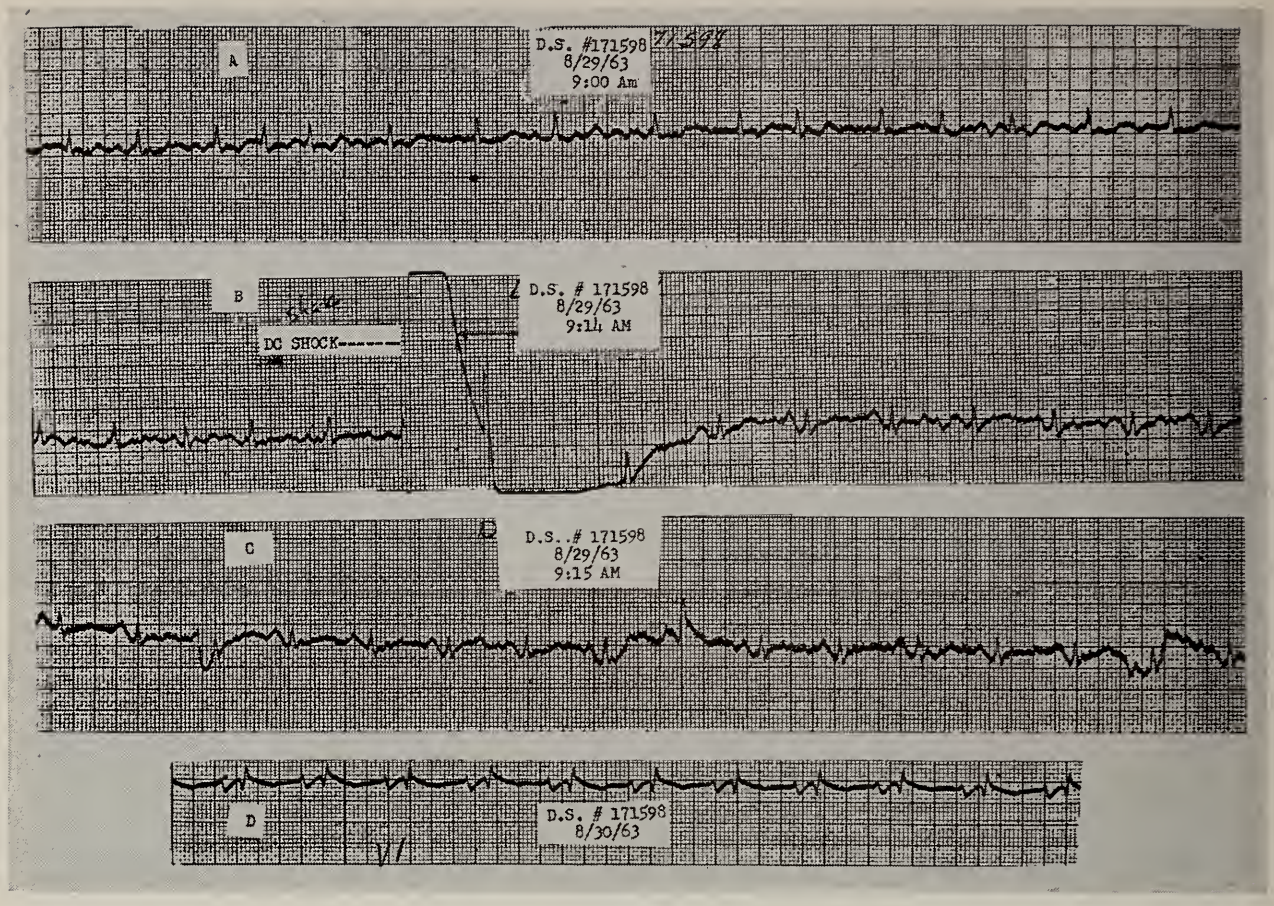


FIGURE 3

(a.) CONTROL TRACING. (b.) Continuous recording during direct current shock. 2.00 seconds delay before the first QRS complex. (c.) Post-shock recording. The third and ninth QRS measure out as sinus conducted beats. (d.) Chest lead V_1 recorded the following day.

Comment: Formerly this patient would have been tried on quinidine. Because of the possibility of embolism we elected to use cardioversion in a controlled situation, i.e. early in the day, and the surgery service was alerted. It had been planned to convert the patient immediately after surgery but the surgery service requested the procedure be delayed until anticoagulation could be effected.

Case 4. A 70-year-old female with diabetes mellitus and chronic auricular fibrillation was admitted to the surgery service where embolectomy from the left popliteal artery was successfully performed. This was the second embolectomy for her in the past two years. Because of her history an attempt at conversion with quinidine was made, with continued oral anticoagulant control. The patient was started on quinidine 200 mgm every two hours for five doses. On the following day, prior to giving quinidine, ventricular tachycardia with cardiovascular collapse developed (Figure 4-b). Direct current shock of 100 watt/second successfully terminated the ventricular tachycardia but auricular fibrillation ensued. Because of the possible depressive effect of quinidine, direct current shock to restore sinus rhythm was not attempted. With continued observation ventricular tachycardia reappeared. Direct current shock of 100 watt/second abolished the ventricular tachycardia in 11 separate episodes. Isuprel, 1 microgram per cc., was given intravenously producing a nodal tachycardia which could be controlled by the rate of infusion. Adequate blood pressure was maintained in this manner without the occurence of ventricular tachycardia. The next morning the patient was found in shock, with ventricular fibrillation. The isuprel drip had stopped. The fibrillation was terminated by one shock of 100 watt/second. Asystole ensued which initially was controlled by external electrical pacing. Total unresponsiveness to any form of

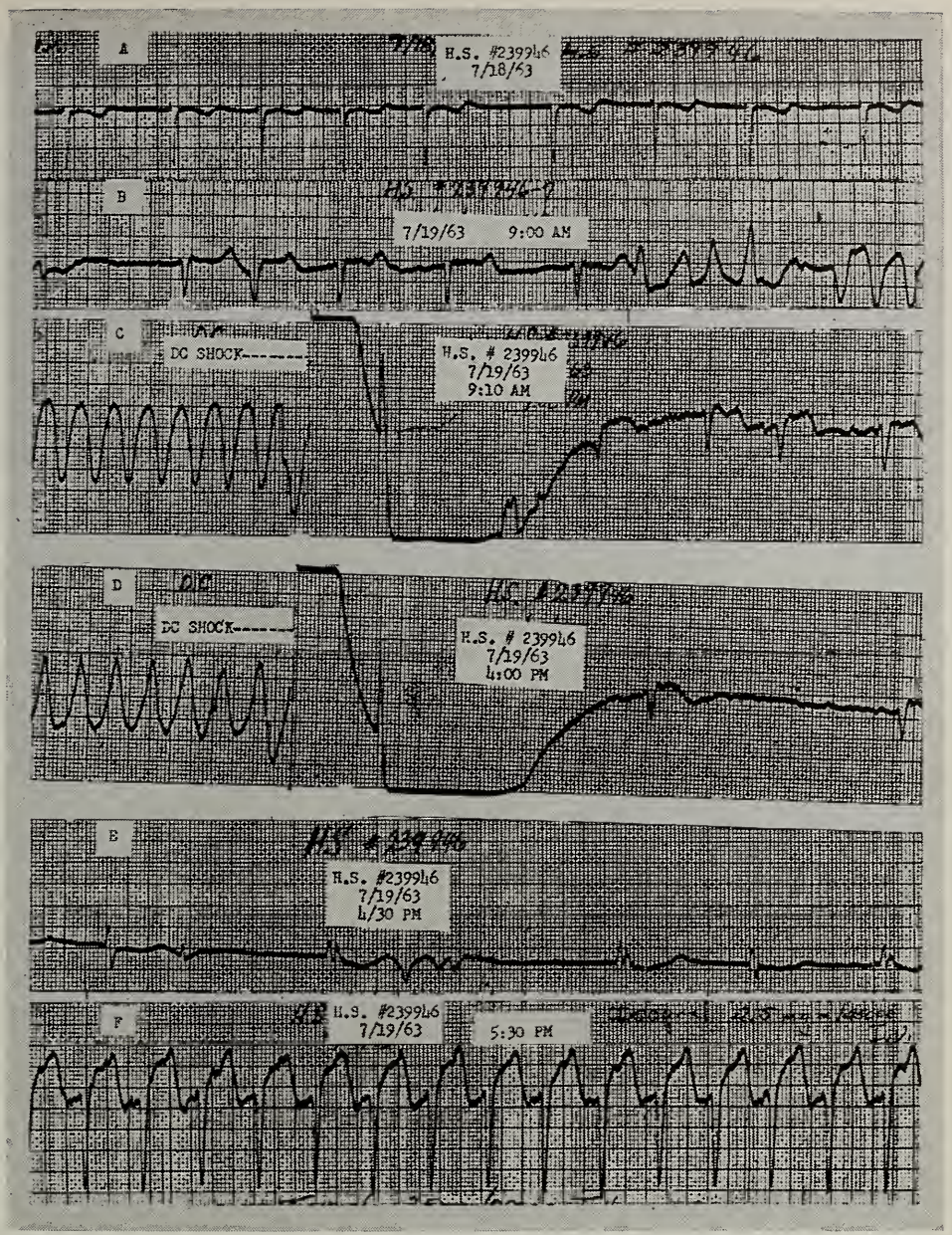


FIGURE 4
(a.) CONTROL TRACING before quinidine administration. (b.) Tracing 14 hours after last dose of quinidine. The patient had received 200 mgm every two hours for five doses. (c. and d.) Termination of ventricular tachycardia with persistence of auricular fibrillation. (e.) Demonstrates the preventricular tachycardia pattern, which would be termed chaotic heart action. (f.) Nodal tachycardia during isuprel infusion, the rate of which could be controlled by isuprel without the occurrence of ventricular tachycardia.

stimulus occurred and the patient died. Throughout the period of treatment the patient was in severe acidosis and unresponsive to large infusions of sodium bicarbonate. Serum lactic acid level was not obtained. A blood quinidine level 17 hours after the last dose of quinidine was 5.7 mg per liter.

Comment: While an autopsy was not performed, we believe the ventricular arrhythmia was secondary to acute myocardial infarction rather than to a toxic effect of quinidine. The direct current countershock was effective in terminating the ectopic ventricular rhythm. It appears that each bout produced more profound acidosis. The duration of ventricular fibrillation prior to the last countershock which resulted in asystole was unknown.

Results

In this series there have been 39 attempts at countershock in 15 patients, eight of whom had rheumatic heart disease, five arteriosclerotic heart disease and one chronic constrictive pericarditis (postoperatively). Two patients received countershock for ventricular tachycardia, one for atrial tachycardia, the remainder had auricular fibrillation. In one patient, (Case 4) sinus rhythm was never restored. Two patients have been lost to follow-up. Of the remaining 12, four reverted to auricular fibrillation while on 1.2 gms quinidine. Two patients have been rescheduled for cardioversion while the other two patients de-

veloped quinidine toxicity while on maintenance doses of quinidine. Of these four patients, three had rheumatic heart disease, the fourth had arteriosclerotic heart disease.

Following shock treatment there were no serious arrhythmias except in Case 4. Ectopic beats were common, those of atrial origin being the most frequent. These usually cleared in the first 30 minutes of observation. There were two cases of A-V dissociation both occurring in patients on large doses of digitalis. Sinus rhythm occurred within the first 30 minutes in each case. Six patients required multiple shocks to convert to sinus rhythm. Of these, four converted on the second shock of 150 watt/second, the fifth required four shocks—the last of 350 watt/second, and the remaining case was Case 4 described earlier.

Two patients were on prophylactic anticoagulation treatment. There were no apparent embolic phenomena. There have been no other changes in the standard electrocardiograms when compared with pre-shock electrocardiograms. All patients remaining in sinus rhythm have a definite clinical increase in exercise tolerance.

Discussion

As an emergency measure in the management of circulatory arrest secondary to ventricular tachycardia or fibrillation, synchronized direct current countershock appears to be the quickest approach to treatment. Certainly, as in Case 1, when there is obvious cardiovascular collapse there is little time for controlled intravenous administration of drugs. Ectopic tachycardias without cardiovascular collapse may be treated in a more conventional manner. We use conventional drug therapy for the first 24 to 48 hours. Frequently we have observed conversion to sinus rhythm. If conversion has not occurred within 48 hours direct current countershock is used. This is especially true in atrial tachycardia or flutter. For ectopic rhythms of undetermined duration, especially atrial fibrillation, it appears that the time honored indications for conversion by use of drugs are applicable with conversion by synchronized direct current defibrillation. Preliminary results, with regard to simplicity, speed and safety, suggest that patients with chronic auricular fibrillation, even though adequately controlled by digitalis, may show increased exercise tolerance with sinus rhythm.

The maintenance dose of quinidine is variable. A daily dose of 1.2 gms is a minimum and may be more nearly 1.4 gms. Because of the variability of patient response it is obvious that two or three shocks may be required before the correct maintenance dose is established. The number of patients who develop quinidine toxicity while on low maintenance dosage may be significant in a larger series of studies.

Anticoagulants were used on two patients in this series because of histories suggestive of embolism. The selection of patients for anticoagulant treatment prior to conversion still remains a problem.[6] Anticoagulant treatment three weeks prior to and one week following cardioversion in all patients with rheumatic heart disease has been recommended by Lown.[4]

Modification of technic may simplify the procedure even more. Placement of the electrodes in the anterior-posterior position, with the heart directly interposed has been performed and conversion to sinus rhythm has been accomplished with less energy—50 watt/second. To obviate the need for an anesthesiologist, patients have been premedicated with only meperidine 0.1 gm and secobarbital 0.1 gm, both given intramuscularly, and have received two or more shocks without ill effects or significant sensation of pain.[7] The selection of the anesthetic or analgesic should be on an individual basis since some patients would be too frightened of receiving countershock while still conscious. In the 15 patients studied all received intravenous methohexital and the electrodes were placed on the anterior chest wall. None of the patients could recall any unpleasant sensations from the shock. There were no skin irritations at the sites of electrode placement.

Summary

Fifteen patients received a total of 39 synchronized direct current countershocks for the treatment of ectopic tachycardias. One patient failed to convert to sinus rhythm. Four patients required a second shock of 150 watt/second, while one patient

required four shocks, the fourth shock being 350 watt/second. Of 12 patients followed one to five months, four have reverted to their ectopic rhythm while on quinidine 1.2 gm daily. There were no embolic phenomena or post-shock arrhythmias of serious origin, except in Case 4. When time permitted, patients were treated for at least 48 hours with conventional anti-arrhythmia drugs before cardioversion. Two patients received anticoagulants before shock because of histories of embolic phenomena. Synchronized direct current countershock for chronic auricular fibrillation is easily accomplished. It appears that patients with rheumatic mitral valvular heart disease are the least likely to remain in sinus rhythm unless large daily doses of quinidine—1.4-1.8 gms are used.

Acknowledgment

The authors wish to thank Drs. William S. Shiels, A. L. Fontanes and the Department of Anesthesiology especially Dr. Gale Dryden for their assistance in this study.

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Side Effects of New FDA Regulations

An important step to acquire new drugs with the utmost safety is the proposed independent "court of appeal" to review disputed FDA decisions on the technical aspects of drug evaluation. For the regulations to insist upon drug safety and drug efficacy is completely unrealistic since all of life is a calculated risk.

Drug safety can never be guaranteed, and product efficacy is even more ephemeral. . . As so often happens when government through ill-advised legislation attempts to regulate private enterprise, whatever evils it hopes to correct are compounded. The new FDA rules, unless drastically modified, will increase drug prices, destroy the small pharmaceutical houses, hamper research, and thus greatly increase the number of untimely and unnecessary deaths.—F. P. Rhoades, M.D., in *Michigan and Wayne County Academies of General Practice Bulletin,* August, 1963.

Report of a Surviving Case

Neonatal Gastric Perforation

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OF OVER 100 reported cases of neonatal gastric perforation, less than 25 have survived.[1,2] It is our purpose to report an additional successful case and to review briefly factors concerned with diagnosis and treatment.

Case Report

The patient was a white male infant born at term after a normal pregnancy. The mother was a 17-year-old gravida I, para 0; labor was induced by an oxytocin intravenous drip. Respirations were spontaneous. Physical examination was normal. The birth weight was 3370 gm. Oral feedings of glucose water were started at 24 hours and were well tolerated. Formula was given orally at 48 hours. At this time the infant was noted to have some respiratory distress, an increased amount of pharyngeal secretions, sternal retraction and poor breath sounds, but no fever. He vomited two feedings, but retained the third. The abdomen was not distended. Four hours later he was noted to be tachypneic, and cyanotic with increased dyspnea. The abdomen was now distended. Oxygen was administered and he was transferred to the Indiana University Medical Center.

Physical examination revealed a pulse rate of 180/min., respiratory rate of 60/min., and temperature 98.6° F. The abdomen was markedly distended and tympanitic. A supine, plain, full body x-ray revealed massive pneumoperitoneum outlining the falciform ligament and the urachus and demonstrating the so-called "football sign." A small and large intestinal gas pattern could be demonstrated, but no gastric bubble could be seen (Figure I).

Following initiation of nasogastric suction and intravenous fluid therapy the infant, now 72 hours of age, was operated upon. The peritoneal cavity was found to be distended with air and curdled formula. There was a perforation on the ventral surface of the stomach 2.5 cm. long running obliquely from the lesser curvature at the esophagogastric junction toward the greater curvature. It was repaired with an inner row of absorbable and outer row of non-absorbable fine sutures without debridement since the edges were clean and viable. The peritoneal cavity was irrigated, aspiration was carried out, and the incision closed.

Procaine penicillin 150,000 units and streptomycin 75 mg. were administered intramuscularly every 12 hours for eight days. Nasogastric suction and intravenous fluids were continued until normal gastrointestinal motility returned on the third postoperative day. At this time oral feedings were begun and advanced to a standard evaporated milk formula. The infant's weight at the time of discharge on the 13th postoperative day was 3011 gm. One month later he weighed 3778 gm. Laryngomalacia, which had been demonstrated by direct laryngoscopy, improved with growth of the child. When last seen, at the age of two, he was doing well.

Comment

The list of etiologic factors in neonatal gastric perforation include peptic ulceration, gastric distention from intubation or resuscitation, birth trauma, necrosis second-

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Aided by a grant from the James Whitcomb Riley Memorial Association.

ary to septicemia and congenital muscular defects. In many instances the cause has not been determined. About one-half of the cases have had ulceration as the predisposing cause. An interesting entity is gastric rupture secondary to a congenital muscular defect.[3] This frequently occurs in premature infants and is associated with a low survival rate. The perforation is usually a laceration on the anterior surface of the cardia or fundus. Several cases have had microscopic proof of the muscular defect. Many of the cases reported as having undetermined etiology may fall into this category.

Infants with gastric rupture usually are born after a normal pregnancy, labor and delivery. Prematurity may be present, however. They generally do well until the third day of life. Symptoms begin insidiously with vomiting and respiratory distress which progresses rapidly. Abdominal distention is then noted. Bowel movements may occur early. Vomiting, respiratory distress and abdominal distention in an otherwise healthy neonatal infant should suggest the possibility of gastric perforation. The later development of abdominal distention may be the result of increased swallowing of air with respiratory distress. It is usually this sign which eventually focuses attention upon the correct diagnosis.

A plain whole body roentgenogram should be made in order to look for the presence of free intraperitoneal air. Although decubitus or upright films are usually required in the adult, free intraperitoneal air in these infants may be demonstrated on a single supine film. With the large amount of free air in the peritoneal cavity which occurs in this condition the falciform ligament is outlined and the "football sign" demonstrated.[4]

It should be remembered, however, that free intraperitoneal air may occur in infants with perforations of small and large intestine. Peptic ulceration, atresia, infection and trauma are the leading causes of perforation in these areas. However, massive pneumoperitoneum of this degree is usually seen only with gastroduodenal or colonic perforations. The presence of massive pneumoperitoneum and the history should suggest the correct diagnosis. Contrast studies will rarely be necessary.



FIGURE I
SUPINE, total body, plain x-ray of the patient at 72 hours of age.

The treatment of gastric perforation is immediate surgical closure. The longer the interval between perforation and closure, the higher the mortality. If closure is performed before six hours have elapsed one-half of the infants survive. If the period is extended to 12 hours the survival rate drops to 44%. At 24 hours the mortality is greater than 70%.* In a recent review of spontaneous gastric perforation, the adult operative therapy yielded a survival rate of 35% while non-operative therapy was associated with 100% mortality.[5]

Conclusions

The successful surgical therapy of an infant with neonatal gastric perforation has been described. This brings to 25 the number of reported surviving cases. The diagnosis should be strongly suspected in a neonatal infant who does well until vomiting, respiratory distress and abdominal dis-

* These figures are computed from references 1 and 2, and include the present case.

tention develop with radiologic evidence of massive pneumoperitoneum. The only survivors are those that have undergone surgical repair. The survival rate decreases as the interval between perforation and operation increases.

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From the Journal 50 Years Ago

. . . The diagnostic laboratory should be in immediate apposition to the working place of the clinician and the surgeon for whom the data is intended. Some time may be wasted by the clinician visiting in the clinical diagnostic laboratory but he is thus kept in closer touch with the results, the methods and ideals of the laboratory. At the same time the laboratory worker is equally benefited by close association with the clinician. Each must understand that the work of both must be closely coordinated to be of highest value to the patient and to scientific medicine. Aside from the technical coordination, good-fellowship must exist between the clinical and laboratory workers, that unpleasant misunderstandings may be avoided.

All of these propositions hold true for the laboratory of surgical diagnosis and here there is also the additional factor of the necessity of immediate returns to the surgeon of data obtained from the examination of fresh tissue while the patient is still on the operating table. Ten years ago most pathologists would have smiled in a superior manner at the proposition to make a diagnosis of neoplasms or of infectious granulomata while the surgeon waited. Within the last ten years, however, we have abundantly demonstrated that not only may such diagnoses be made within a few minutes after the receipt of the tissue in the laboratory, but that they may be correctly made, and further that in some instances data unobtainable in fixed tissue may be found in the freshly stained tissue.

The diagnostic laboratory in close relationship to the operating room is as important as is the sterilizing room. No hospital should be permitted to run an operating room in which patients with tumors of doubtful malignancy are operated on unless it at the same time maintains a diagnostic laboratory and a competent pathologist. . . . Louis B. Wilson, M.D., "Laboratory Efficiency" *JISMA*, March, 1914.

Adrenal Cysts

MANUEL LARGAESPADA, M.D.
KINGSLEY LAWRANCE, F. R. C. S.
*Indianapolis**

BENIGN CYSTS of the adrenal gland are relatively rare, they are of obscure endocrine significance and are usually successfully treated. This report we believe is the 160th in the world literature;[6,7,9,13] it also appears to be the fourth reported case in which endocrine abnormalities have been found.[8]

Case Report

An 18-year-old white female, (Figure 1) was admitted to the receiving ward of Marion County General Hospital on August 30, 1962 complaining of constant, severe left upper quadrant pain. The patient had nausea without vomiting; this was her first such episode. The only outstanding feature in her past history was amenorrhea of three years duration following her menarche at age 11.

Physical examination showed an obese white female in acute distress with truncal fat distribution, no striae and moderate nasolabial hirsutism. Abdominal and pelvic examinations were negative. During her hospital stay her pain shifted to all abdominal quadrants but there were no objective findings. Gastrointestinal series were normal and cholecystogram visualized well without evidence of calculi. Intravenous pyelogram showed a mass depressing the left upper pole of the kidney (Figure 2).

Laboratory examinations were as follows: hemoglobin—15.0; hematocrit—40; white blood count ranged from 5,500 to 9,000 with normal differential; fasting blood sugar—72; glucose tolerance—1/2 hour: 153 mgm.%, 1 hour: 170 mgm.%, 2 hours: 157 mgm.%, 3 hours: 149 mgm.%; blood urea nitrogen—14.2; buccal smear showed 40% chromatin positive; cortin—7 mgm.%; 17-ketosteroids—7.9 mgm./24 hours; 11-hydroxysteroids—10.8 mgm./24 hours; calcium—8.4 mgm.%; phosphorous —4.2 mgm.%.

The patient was operated on September 24, 1962 through an upper transverse incision. A cyst approximately 10 cm. in diameter was found involving the left adrenal gland. The right adrenal appeared normal as well as the large and small bowels and all of the pelvic organs. The mass and the left adrenal gland were resected with some difficulty due to the tight adherence of the mass to the posterior abdominal wall. The cyst ruptured during manipulation. The patient required one unit of blood during surgery. She made an uneventful recovery and menstruated three weeks postoperatively. Her pain recurred four weeks after surgery and continued intermittently for the next three months until it finally disappeared. Her postoperative laboratory values were nearly identical to the preoperative ones.

Histology

Small slit-like spaces can be seen surrounding the main cavity both parallel and perpendicular to it (Figure 3, 4). Their lining is similar to that of the main cyst and is of the endothelial type. No abnormalities can be seen in the adrenal gland which makes one of the walls of the main cyst. Diagnosis: lymphangiectatic cyst of the left adrenal gland.

Although the true diagnosis was not suspected pre-operatively in this case, it was considered possible that a close relationship existed between the patient's history and the appearances of the intravenous pyelo-

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FIGURE 1
POSTOPERATIVE views of patient showing obesity distribution and hirsutism.

grams. No explanation can be given for the cause of pain nor its postoperative persistence and eventual disappearance. The patient's physical appearance, menstrual history and abnormal glucose tolerance curve, however, cannot be disregarded as mere coincidence. Long term follow-up will be necessary to determine what effects, if any, the operation will bring.

Discussion

The first case of adrenal cyst was reported by Greiselius in the 17th century.[5] He referred to a case in which a hemorrhagic cyst ruptured into the peritoneal cavity and resulted in the patient's death. Hildebrand in 1896[7] described the first case in which surgery was successfully carried out. The first case operated on in the United States was reported by H. E. Pearse[4,12], his case was associated with an enlarging mass, bleeding and shock. He successfully marsupialized the cyst and the patient recovered.

The cysts occur most frequently in the fifth and sixth decades and are relatively rare in children[2,3]. Women have this lesion more frequently than men, at the rate of three to one. They are often asymptomatic or otherwise associated with vague gastrointestinal disorders. At times an enlarging



FIGURE 2
PRE-OPERATIVE intravenous pyelogram showing depression of right upper kidney lobe.



FIGURE 3
APPEARANCE of gross specimen.

mass heralds the lesion.[1]

No predilection for either adrenal gland could be discovered; they are rarely bilateral and no report could be found of cystic changes in ectopic adrenal tissue.

Diagnosis is seldom made pre-operatively[7] although an adrenal lesion is nearly always suspected after such tests as intravenous pyelography, retrograde pyelography, abdominal roentgenography, gastrointestinal studies and perirenal air insufflation.

The treatment of choice is surgical enucleation with preservation of the ipsilateral kidney. If the diagnosis could be established without exploration, then the possibility of expectant therapy might arise, since no ill effects could be attributed to the cyst in

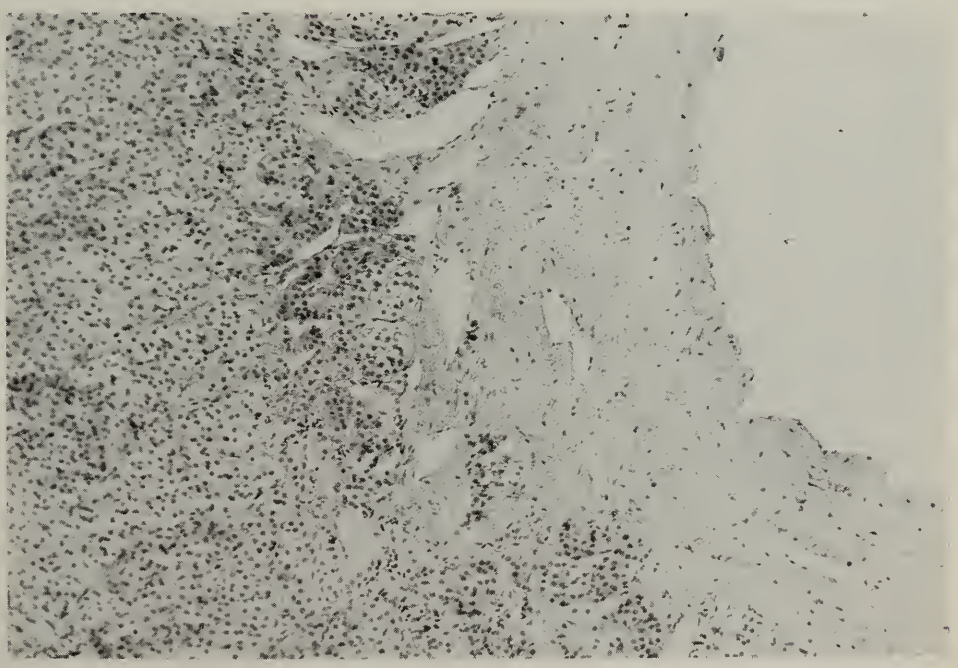


FIGURE 4
MICROSCOPIC view of cyst wall showing slit-like lymphangiectatic spaces.

many of the 88 cases diagnosed at autopsy.[3,7]

The classification of adrenal cysts, shown in Table I,[2,11] is the most frequently accepted; the present case represents an example of lymphangiectatic cyst.

CLASSIFICATION OF ADRENAL CYSTS[2,11]

I. Parasitic cysts — Rare; usually due to echinococcosis.
II. Epithelial cysts.
 A. True glandular: rare; occurs only when adrenal cellular components tend to form.
 B. Embryonal cysts: cylindrical epithelium; displacement of tissue from urogenital anlage with cystic transformation.
 C. Cystadenomas: adenomas with cystic transformation.
III. Endothelial cysts — Second most common variety in adults.
 A. Lymphangiectatic: multilocular, flat endothelial lining.
 B. Angiomatous: rare; may be associated with angiomats of liver and/or skull.
 C. Hamartomatous: improper tissue proportion of various elements; rare.
IV. Pseudocysts — Most common type.
 A. Hemorrhage within normal adrenal tissue.
 B. Pseudocysts secondary to cystic degeneration of adrenal tumors.

TABLE I

There are only four cases in the literature in which mention is made of definite endocrine abnormality. The first such report was made by Levinson[10]; his patient was also the first in which roentgenography led to the diagnosis. This lesion was bilateral and surgical extirpation did not alter the course of her pluriglandular endocrinopathy. While endocrine abnormalities have been recognized in other cases, no elevated 17-ketosteroid levels could be found in any instance to substantiate an incontrovertible case of Cushing's syndrome. No reports have been made of cysts associated with adrenal abnormalities produced by pituitary disturbances. Only Levinson's case might have fallen in that category.

Summary

Adrenal cysts are relatively rare, usually unilateral lesions of uncertain endocrine significance. A case is presented in which some endocrine abnormalities were found. The diagnosis and treatment of adrenal cyst is discussed, together with the relationship between this condition and endocrine abnormalities.

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The Association of Calcific Valvular Disease and Retinal Embolization

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IT HAS BECOME increasingly apparent that spontaneous calcific embolization occurs in a significant number of individuals with calcific valvular disease. It has recently been verified pathologically[1] that a calcific stenotic aortic valve serves as a site from which calcific emboli can disseminate spontaneously. There was a total of 45 emboli reported in 37 patients. Thirty-two emboli were found in the coronary arteries, 11 in the small branches of the renal artery, one in the right middle cerebral artery and one in the central retinal artery.

In a review of aortic stenosis, Baker and Somerville[2] reported visual disturbances as part of the symptomatology. They felt it noteworthy that patients with calcific valvular disease, (two out of their 50-patient series and two patients not included in their series), developed sudden loss of vision in one eye. When these patients were examined two to five years later, they had visual field defects, and retinoscopy revealed occlusion of a retinal artery branch with neovascularization. Although they could find no evidence of emboli elsewhere, they wondered if these retinal defects were not due to minute calcific emboli. Hollenhorst[3] has reported three cases of suspected calcific emboli in patients with roentgenographically demonstrable calcified cardiac valves.

The following case is felt to be an example of spontaneous calcific embolization of a retinal arteriole which the authors have had the opportunity to follow for two years.

*From the Department of Medicine, Veterans Administration Hospital and the I.U. School of Medicine.

This work was done during Mr. Horn's tenure as an Indiana Heart Association student research fellow.

Supported by the Indiana Heart Association.

Case History

A 35-year-old white male was admitted to this hospital on July 18, 1960, complaining of sudden partial blindness in the right eye. He stated that one week prior to admission he had awakened to find himself partially blind in the right eye; this was unassociated with other symptoms. Two days after the onset of visual disturbances, the patient consulted an ophthalmologist who considered that he had a small piece of calcium lodged in the right eye.

In 1943, the patient was discharged from the Navy with a diagnosis of rheumatic heart disease, but he was entirely asymptomatic. He was subsequently seen at this hospital in 1944 for evaluation of his cardiac status, and a history compatible with rheumatic fever at age 14 was elicited. Laboratory studies including routine blood examinations, chest films and electrocardiograms were within normal limits. He was discharged with a diagnosis of rheumatic heart disease manifested by aortic and mitral insufficiency.

Physical Examination: At the time of admission in 1960, cardiac examination revealed the blood pressure to be 120/80 and the pulse 80 and regular. The P.M.I. was just outside the left midclavicular line. No thrills were felt. It was noted that a Grade I/VI blowing diastolic murmur and a Grade II/VI systolic murmur were heard best over the 3rd left intercostal space. There was a Grade III/VI apical systolic murmur of a different quality transmitted throughout most of the precordium. No apical diastolic murmur was heard. The electrocardiogram was within normal limits. At this time cardiac fluoroscopy demonstrated a calcified aortic valve. Right heart catheterization

was performed at this time, and studies revealed a normal output at rest and with exercise. In view of this, left heart studies were not performed. There was no evidence of bacterial endocarditis at this time. Since 1960, the patient has been seen on numerous occasions. The ophthalmologic examination revealed the right inferior temporal artery to be occluded and a right superior temporal field defect to be present (Figure 1). Ischemic changes were noted just inferior to the macula. At this time, the cause was felt to be embolic in nature but of unknown type. The patient was placed on heparin shortly after admission and then subsequently maintained on Dicumarol because it was assumed that the patient had had a retinal embolus from thrombi in the left side of the heart.

On December 10, 1962, retinal Kodachromes (Figure 2) were obtained which clearly demonstrated the presence of a ghost vessel with a fleck of chalky-white material thought to be calcium, blocking the lumen. Copies of these Kodachromes were reviewed by Dr. Robert W. Hollenhorst, who agreed with this interpretation[3]. This lesion corresponds to the original area of retinal occlusion. There are full tortuous vessels in this area representing neovascularization. It is notable that no other atheromatous or calcific areas are seen in the retinal photograph. In view of the history and photographic findings, our ophthalmologist considered the lesion to represent a calcific embolus presumably originating from the calcific aortic valve.

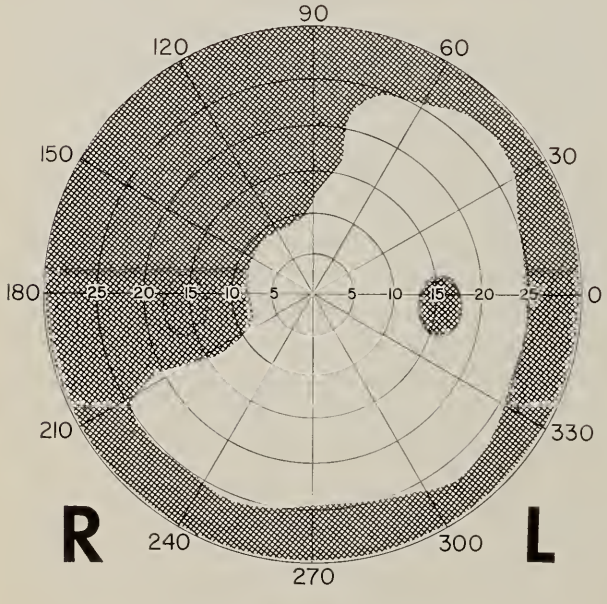


FIGURE 1

VISUAL FIELDS: a right superior temporal field defect is demonstrated.

Discussion

Considering the differential diagnosis pertinent to this case, it seems most important to distinguish a calcific embolus from what Hollenhorst[3] calls a "bright plaque." He describes a total of 31 patients with cerebral vascular occlusive disease who developed "bright plaques" located at the bifurcation of retinal arterioles. These plaques were orange, yellow or copper-colored and rarely occluded the retinal arterioles or caused permanent loss of vision. With time some of these plaques were observed to move to more distal bifurcations, and some broke into smaller fragments and disappeared. This type of plaque was observed in five out of 35 patients undergoing carotid endarterectomy and appeared during the operation. Although not confirmed pathologically, it was suggested that these plaques were either cholesterol-crystal emboli or liquid cholesterol originating from eroded atheromatous lesions in the aorta or the innominate, carotid or ophthalmic arteries.

In distinguishing the calcific embolus originating from a calcified cardiac valve from the "bright plaques" described by Hollenhorst, several differential points become apparent. The calcific embolus has a characteristic chalky-white appearance which differs significantly from the color of the "bright plaque." In considering the effect of the embolus, it is to be noted, at least in this case, that the visual defect produced by the calcific embolus was sudden and permanent, and no migration of the embolus was observed. Finally, the presence of calcific cardiac valvular disease in the patient with sudden loss of vision should lead one to suspect the possibility of a calcific embolus.

One must also consider the possibility of a thrombosis occurring in an arteriole around a preformed calcium-containing plaque, but it is generally felt that this process does not affect the retinal arterioles as an isolated lesion. In this patient there is

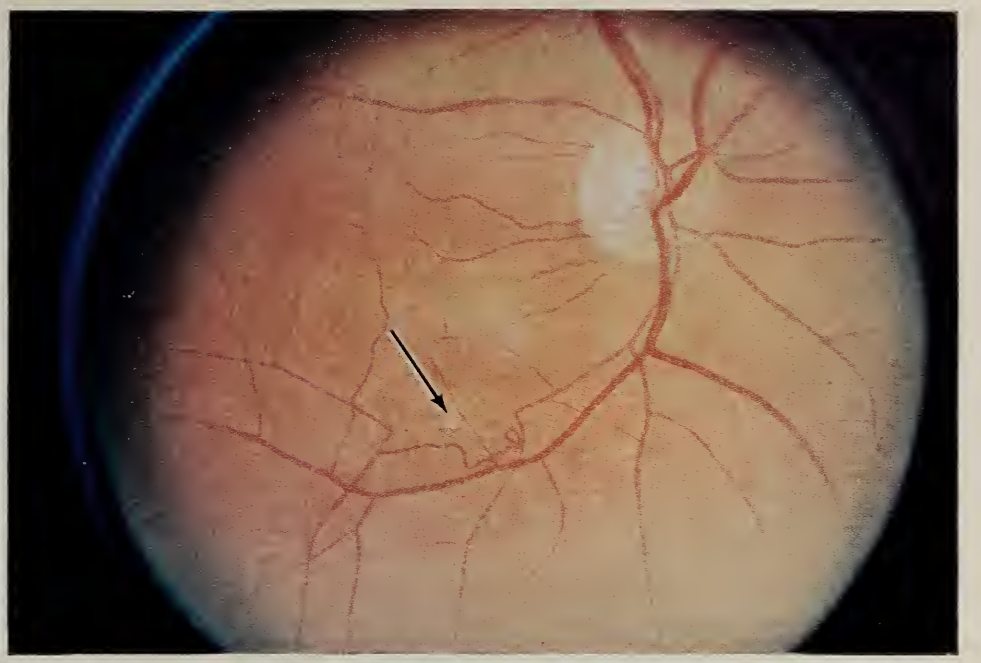


FIGURE 2
THE SMALL WHITE FLECK just below the center of the photograph is the arterial lesion with the "ghost" of the vessel wall extending to either side.

no evidence of retinal atherosclerosis.

The practical value of making a diagnosis of calcific embolization of a retinal arteriole is seen in the treatment of this condition as opposed to the treatment of many other forms of retinal embolization. It would appear that anticoagulants are the treatment of choice, at least in the case of the "bright plaque"[3] and in the management of patients with thrombo-embolic phenomena originating in the left side of the heart. This regimen would be of no value in calcific embolization. The importance of the correct diagnosis is aptly demonstrated in that the patient described above underwent two years of unnecessary anticoagulant therapy.

Summary

A case of spontaneous calcific embolization to the inferior temporal artery with a follow-up of two years in a patient with calcific aortic valvular disease is described and its implications are discussed.

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Bottles and Bearings

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Westville

FOR YEARS I have been obsessed with the proposition that the dearth of applicants for enrollment in medical schools is directly proportional to the efforts of the medical profession itself. Being the parent of a fine young recent graduate of a residency in radiology, it has, of late, appeared to me that maybe it is sex (as it may affect the future practitioner) that is at the root of this serious situation. When I raised this subject at a family gathering, hoping to find a solution to the problem, a chilling silence ensued.

Upon further consideration I felt that sex, even it if be presented in a deviated form or pattern, can perhaps help to influence a worthy young man to follow the noble profession of medicine.

I have, on many occasions, refuted arguments against this theory by relating the following true instances:

While an intern in a hospital in South Bend, I was called to the emergency room in the middle of the night. Upon arrival there, I was confronted by an elderly patient who had that time-worn complaint of too much alcoholic intake complicated by the existence of an enlarged prostate. (This is an old bugbear of the intern service causing untold hours of lost sleep.)

After this emergency was disposed of and the patient's bladder was lowered from the level of the umbilicus, he left the premises to do the same thing another day. His supposed companion, however, did not leave and when asked what his nocturnal difficulty might be, replied, "I have hemorrhoids and someone told me to reduce them with a bottle." When asked what result had been achieved, the reply was that the bottle had disappeared.

In the young, inexperienced mind of the intern, this was attributed to inebriated maundering. However, the proof of the pudding was in the rectum of the patient. In the knee-chest position it was determined that the patient, indeed, was correct—the bottle had disappeared.

An attempt to remove the bottle was made with eight inch forceps but it is difficult to secure a grip on the edge of the lower end of a bottle. Larger implements were needed to solve the problem. Accordingly, the obstetrical department was thought of as a possible source of instruments to solve this unique situation. Don't ask why! A decapitation hook shaped like a T—rarely used these days, fortunately—was present in the instrument cabinet. A set of obstetrical forceps was also selected. At this time a fellow physician was asked if he wanted to help officiate in the delivery of a bottle.

The mouth of the bottle could be felt in the abdomen and the procedure, which to my knowledge has never been reported, is to pass the decapitation hook from below and turn it to fit in the mouth of the bottle. With an assistant's help, and with one blade of the obstetrical forceps to guide the lower end of the bottle over the curved sacrum and coccyx, the combined maneuver is sufficient to deliver a half-pint milk bottle from the rectum.

A Novel Introduction to Medicine

The author later selected a fine, young, worthy high school student with a history of a deficient family background and finances, a condition we were all in in those days, to help to become a physician. The bottle incident was reported to him in the process of his education and it is again emphasized that sexual deviation was an important factor in his decision to continue with his education.

This young man was asked to drive his mentor on a call to a filling station and

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house combination at a nearby lake. Upon arrival there, when asked where the patient was, a chilling atmosphere was encountered. "He" was in the back room, sitting on the edge of the bed with a pan of water with ice cubes and a wash cloth floating in it. Investigation revealed a greatly engorged and enlarged male organ with a doughnut-shaped car wheel bearing next to the abdomen, rendering manual removal impossible.

When asked how such a revolting situation occurred, the man said he had been sleeping in "the grass the night before" and some youngsters had crept up and slipped the bearing on him.

A file was asked for, its use was a futile gesture in solving the situation. A hacksaw failed to even scratch the case-hardened metal. In scrounging in the backyard shed, an axe, chisel and a small section of railroad rail were found and tried as a means of treatment. At each stroke of the axe and chisel on the bearing, which was resting on the section of rail, a loud moan was the only result. Next the prospective medical student was sent to the nearest garage for a pair of bolt cutters. These too failed to crack the case-hardened metal.

It was obvious that something had to be done, accordingly the patient was given a shot and driven to the nearest hospital, 30 miles away.

There, the most capable surgeon in that area completed the treatment of this unusual emergency. A pair of bolt cutters broke in an attempt to crack the bearing. The janitor, my young friend, and the surgeon then took the patient to the basement of the hospital. There they held him horizontally at the level of a vise, (if one can picture such a position) and with this leverage, the bearing was cracked and removed.

With the knowledge of these two emergencies and their solution, the young man was easily persuaded to complete his medical education at a Chicago medical school and has been practicing in an Illinois city for some years.

During the course of his internship, the experience of the bottle incident and its solution, as told to him, proved useful when a similar incident occurred at the hospital in Chicago.

A Chinaman was admitted with a bottle in his rectum. The young physician tried to solve the situation with the use of obstetrical forceps but the suction was too great, and the attempt failed. The patient was taken to surgery and the colon was opened. The bottle was capped and inscribed on the cap was the inscription, "Shake Well"! This particular bottle had contained French dressing. It was large at the bottom and small at the top. Unfortunately, this patient did not survive.

Even with this apparent setback, this young man graduated into our profession, wiser no doubt than some fellow members, and is now able to hold his own in any given social gathering of his peers.

Immediately following the writing of this article, I was confronted with a similar problem and, with my prior experience in this field, I was easily able to solve the problem. A criminal sexual psychopath was admitted to the emergency room with a foreign body in his rectum which he explained he placed there because he was depressed and was "fooling around."

Examination revealed an object high in the rectum about a finger's length. A proctoscope was used but the object was too high to visualize. With the use of a gloved finger and a dressing forceps, and with pressure above, the object was removed. The object was nine inches in length and made of a one-inch square towel rack, superimposed on one end was a cup-shaped piece of plastic. The entire object was wrapped with masking tape having an overall resemblance to the male sexual organ.

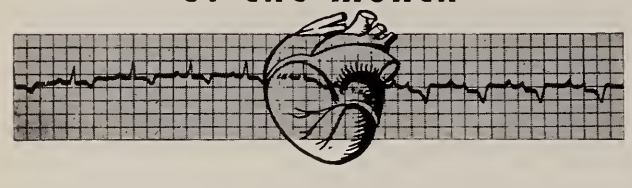
G. P. = General Practice or Psychiatry?

The above experiences and their solutions are ample proof that a general practitioner is not only needed but well suited for institutional work. With a smattering of Freudian principles an experienced general practitioner is a valuable addition to the milieu of a state institution.

The author, has thus been able to report cases of four dire emergencies, surgical and psychiatric, in the practice of medicine.

The idea of medical careers exhibits to promote interest in prospective members of our profession is of great value but the best solution may lie in our own backyard. ◄

Electrocardiogram
of the month



Presented as a regular feature of The JOURNAL, Electrocardiogram of the Month is a series of short talks on cardiovascular diagnosis and treatment, edited by the staff of the Krannert Heart Research Institute, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis.

Atrial Flutter with a 1:1 Ventricular Response

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THE PATIENT, a 47-year-old man, was seen in the emergency room because of a rapid heart rate complicated by shock. Electrocardiogram (Figure 1-A) disclosed a regular ventricular rhythm at a rate of 240 per minute. The rapid rate and the regularity of rhythm rules out ventricular tachycardia and the most likely diagnosis is paroxysmal atrial tachycardia. Because of the serious hemodynamic complications of the rapid rate, digitalis was given intravenously with a prompt reduction of the rate to 120 per minute. An EKG (Figure 1-B) disclosed that the underlying mechanism was an atrial flutter with a 2:1 response and that the rate of 240 was due to an atrial flutter with a 1:1 response.

Atrial flutter with a 1:1 response is a rare arrhythmia usually superimposed on severe heart disease and in itself, unless treated, produces profound shock, angina which may lead to myocardial infarction and congestive heart failure. The treatment of choice is digitalis and depending on the severity of the manifestations, the route of administration may be either oral, intramuscular or intravenous.

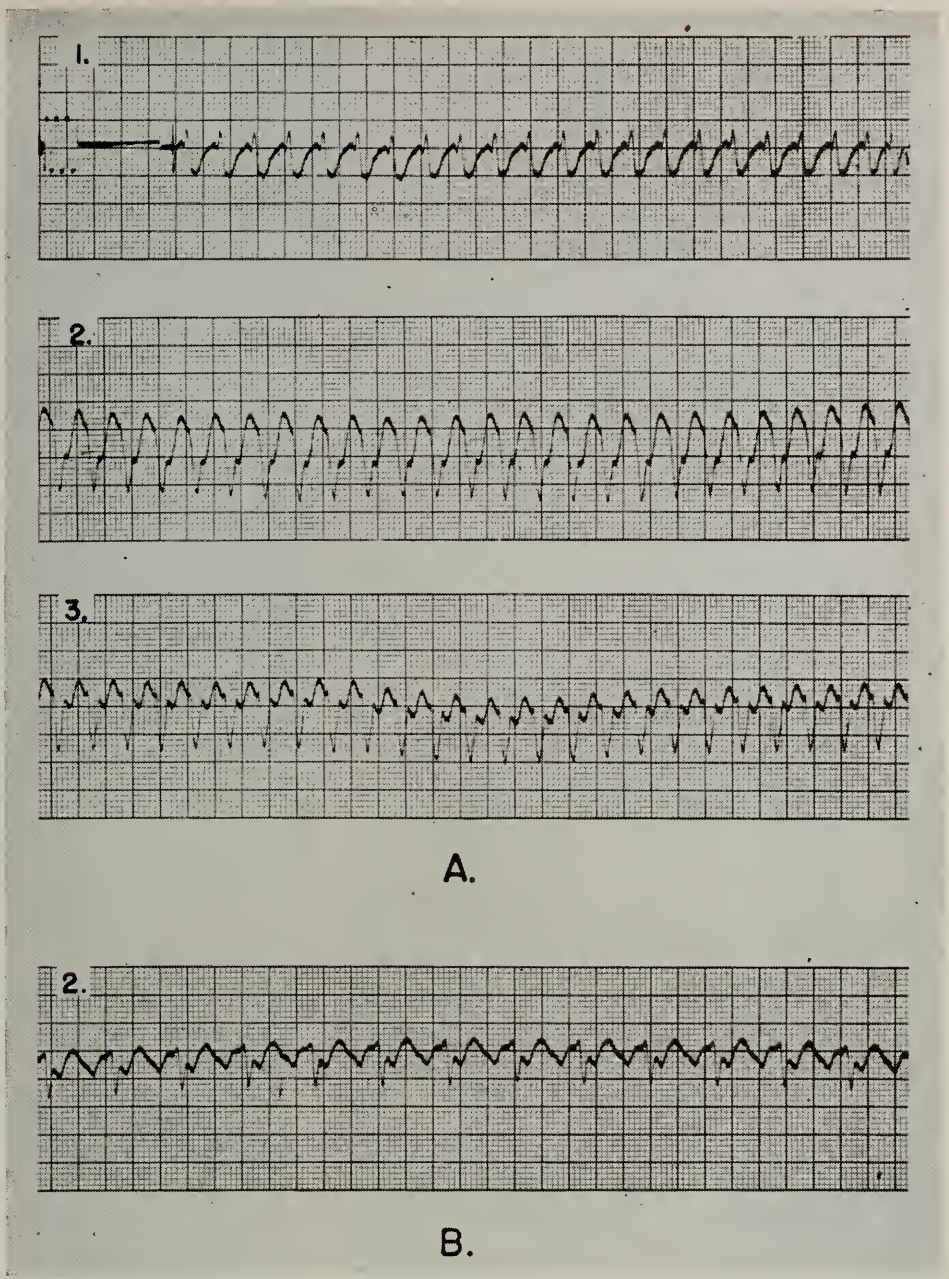


FIGURE 1
ATRIAL FLUTTER with 1:1 response (A) and 2:1 response (B).

X-RAY CONFERENCE

Presented as a regular feature of *The Journal*, X-ray Conference is a series of short talks on procedure and radiologic diagnosis, edited by Erich K. Lang, M.D.

Renal Hypertension

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A 42-YEAR-OLD white female was admitted to Methodist Hospital for hypertension developing during the past six month period. Originally the hypertension was thought to be of the labile type; however, of late, sustained hypertensive values of approximately 220/110 in both arms were recorded. Urinary and blood catecholamines were negative. The Regetine test was equivocal. An intravenous pyelogram revealed a slight disparity in size of the right and left kidney, the right one measuring 10.2 x 4 cm. and the left one 12.5 x 4.5 cm. On the right side the parenchymal thickness was decreased to 1.7 cm.

The hypertensive survey intravenous pyelogram showed a significant delay in the appearance of the nephrographic stain on the right side. The right kidney failed to show a significant stain until the 3-minute film whereas the left side showed a normal stain on the 30-and 60-second films. A corresponding delay in dye excretion was observed. Slight increase in dye density in the right kidney pelvis was felt to be present on the 30-minute film. An urea flush study revealed prompt dye disappearance from the left kidney pelvis; on the right side the dye appeared to be retained. Fifty grams of urea in 200 cc. of saline solution were introduced intravenously within 10 minutes for this study. A renal arteriogram demonstrated a typical "napkin-ring" constricting lesion of the right renal artery followed by post stenotic dilatation. The nephrographic stain phase of the arteriographic study (the 6-second film) revealed a significant decrease in the dye stain of the right kidney. Both the Howard and Stamey tests were positive on the right side. A renogram performed with radioactive hippuran revealed a 40% depression of the plateau of the curve on the right side.

A pressure gradient of 80 mm. mercury was recorded across the stenosis during the surgical exploration. An endarterectomy was carried out and a venous patch graft



FIGURE 1
THE LEFT AND RIGHT kidney pelves show equal dye density.

* Radiologist, Methodist Hospital.



FIGURE 2

AFTER INFUSION of 50 grams of urea in 200 cc. of saline carrier most of the contrast medium has cleared from the left kidney pelvis. On the right side the dye tends to remain, a finding indicative of a significant arterial lesion.

was utilized to close the surgical endarterectomy site. The patient responded with prompt reduction of her systolic and diastolic pressures. Six months after the operation her pressure had dropped to 160/80.

Discussion

The diagnostic armamentarium in renal hypertensive disease includes both physiologic and roentgenographic tests. The most important physiologic tests are based on an assessment of the ability of the ischemic kidney to conserve water (increased water re-absorption). The Howard test specifically tests for sodium and water conservation. The Stamey test utilizes clearance substances and compares the ability of the two kidneys to conserve water by an assessment of these clearance substances. Both tests depend on an accurate collection of urine from the kidney pelves by indwelling ureteral catheters.

Renograms with radioactive hippuric acid reflect the total vascular pool of the kidneys. This highly physiological test is particularly useful in the interpretation and diagnosis of arteriolosclerosis of the peripheral renal arteries.

The roentgenographic methods include assessment of the kidney size on the plain film and/or intravenous pyelograms. The hypertensive survey intravenous pyelogram attempts to assess the appearance of the early nephrographic stain. The ischemic kidney tends to show a delayed appearance of this nephrographic stain. The 30-second, 60-second and two-minute films are particularly useful in the interpretation of an early nephrographic stain pattern. The dye density in the renal pelvis on delayed films is likewise useful in the assessment of ischemic disease since the kidney with vascular impairment will tend to conserve water and, hence, show greater dye density in the kidney pelvis. This can be accentuated by the "urea flush technic." Approximately 50 grams of urea are infused intravenously in 200 cc. of saline carrier. The normal kidney will readily flush its dye content from the pelvis. The abnormal kidney, conserving water, will show little or less flushing of the pooled dye in the kidney pelvis.

Finally, the most reliable and definitive test is the renal arteriogram. Catheter



FIGURE 3

THE ARTERIOGRAM demonstrates a classical "napkin-ring" constricting lesion of the main right renal artery followed by a post stenotic dilatation. The lumen is narrowed to less than 30% of normal width. A small plaque is also seen in the main left renal artery but is not felt to be significant in nature.

arteriography with "flush technic" is best suited for the demonstration of ischemic lesions. Lesions of both the orifices of the renal arteries at the aorta, as well as the peripheral portion of the renal arteries, can be readily demonstrated. The method offers a distinct advantage over selective arteriography where lesions at the orifices of the renal arteries or lesions of small accessory renal arteries may be missed.

Arteriograms are best carried out in the upright and supine positions since several lesions, particularly fibromuscular dysplasia, are only demonstrated in the upright position. The five to eight-second delayed films show the later capillary and early tubular phase. A comparison of the densely stained kidneys allows assessment of the overall staining characteristics and demonstrates small areas of non-staining such as small cysts and small peripheral infarcts. ◄

About Our Cover

A Medical Explorer program was started in Indianapolis three years ago, and the October, 1961, issue of *The Journal* carried a story of its early days. The growth of this venture has been tenfold. The number of doctors actively participating has risen from 30 to 300. From a pilot group of 20, there will soon be 200 boys, age 15 and older, representing 30 high schools, enrolled as members of Explorer Posts. Sponsors include Eli Lilly & Co., Paul Coble American Legion Post, Methodist Hospital of Indianapolis, Morgan County Hospital at Martinsville, members of the Shelby County Medical Society in Shelbyville and the Boone County Medical Society in Lebanon. (There are other Indiana groups including a Future Doctors Club, sponsored jointly by the Howard County Medical Society and Kokomo High School.)

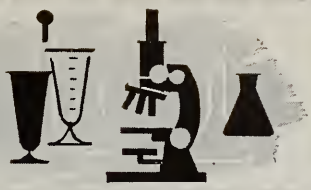
The Explorers have participated both as observers and technicians in such diversified fields as American Red Cross First Aid, General Practice, Internal Medicine, Pediatrics, Anesthesia, General Surgery, Orthopedics, Neurosurgery, Obstetrics, Ophthalmology, Otolaryngology, Urology, Radiology, Clinical Laboratory, Pathology, Forensic Medicine, Cardiac Research, Anatomy, Physiology, Laboratory Research (even glass blowing), Emergency Room Care in large hospitals and "County Seat" medicine in smaller hospitals. They have toured the Eli Lilly Co., Bunker Hill Air Force Base, Glenview Naval Air Station Space Medicine Center, Krannert Heart Research Institute, and all the hospitals in Central Indiana, including I. U. Medical Center.

With our ever increasing population we must recruit for the medical and paramedical professions. Medical Explorers get vital encouragement while they are still young enough to have an open mind, yet interested enough to start thinking of more serious plans for their future education. With 150 boys in the program, there must be over 500 family members (not counting the acquaintances and high school faculty members,) who are also getting a different view of their doctors. They see dedication to expanding the profession by this thrilling experience for a young boy. Many parents have said they did not dream that so many doctors would help do this. For them, a not unusual image has been the harrassed medic worrying about uncollected bills, his overloaded schedule that will make him late for the golf course, the cocktail party orator who is always fighting for his freedom and against socialized medicine.

We salute the many doctors who participate in this fine, constructive program for their generosity of time, knowledge, patience and forethought. The Central Indiana Council of Boy Scouts of America Explorer Specialty Program (and its "Chief Wahoo"—Dr. Max Norris) have become the authority and model for the whole country. Indiana can truly be proud.

The badge reproduced on our cover is the Explorer Scout Badge, and it is hoped that in the not too distant future, the Medical Explorers will wear their "own" insignia, just as they now wear white lab coats. The lines at the bottom of the cover are from the "Explorer Code."—R.W.H.

Path-finder
PUBLISHED UNDER THE AUSPICES OF THE INDIANA ASSOCIATION OF PATHOLOGISTS



Medical Progress, the Pathologist and the Cost of Medical Care

LEON L. BLUM, M.D.
Terre Haute

WE ARE WITNESSING an extraordinary progress in medical science and practice. The rapid advances in all branches of clinical pathology (laboratory medicine) are astonishing and overwhelming. Daily, weekly and monthly, new tests or modifications of older procedures are being reported and their use for diagnosis and treatment urged. Mushrooming commercial laboratories swamp the busy practitioner with unsolicited literature, advertising, mailing containers and price lists. The busy clinician often becomes the confused "victim" of medical progress and advertising in his selection of laboratory tests. The "art" of medicine suffers and the patient loudly voices complaints about the high cost of medical care.

Many laboratory tests, performed without strict indication or clinical correlation, often via "catalog mail order," are worthless and unnecessarily increase the cost of medical care. However, selected with discrimination, knowledge of clinical history and properly correlated with clinical findings, they contribute greatly to early detection and proper management of many clinical conditions. They may prevent or shorten lengthy and costly hospitalization, an important factor in the rising cost of medical care.

The clinical pathologist can help the general practitioner or specialist to increase the value of his services to his patients and the community. By training and experience, he is qualified to act as a true clinical consultant for maximum benefit to the patient as well as the attending physician. Today it is almost impossible for the clinical pathologist to keep abreast of all new developments in laboratory medicine; therefore how can one expect a busy clinician to do so? Yet, it is essential, in the maze of new developments in laboratory medicine, to shorten the time span between significant discoveries and their applications to daily practice in rural, urban and metropolitan communities.

Clinically Proven Tests Preferable

It is, however, neither economically feasible nor scientifically desirable to immediately set up any new test which Dr. X may order after learning about it in a medical meeting or journal. Many new tests are time consuming, expensive, need special reagents or equipment and may not furnish the desired information. New tests come and go and Dr. X may soon lose interest in the requested test leaving the laboratory with a batch of rarely used, unstable reagents and frustrated feelings. The cost of medical care need not be increased and can often be significantly reduced by judicious application of clinically proven screening and analytical laboratory methods. The "art" of medicine will not suffer and the public "image" of the physician may improve.

To bring to your attention the value of

newer laboratory aids in your daily practice is one of the primary functions of the *Pathfinder* page. We try to convey our ideas in a form attractive to the mind as well as to the eye. For this year we plan a series of brief articles dealing with some newer methods of detection of preclinical stages of disease. Your comments, queries and criticisms will be welcome. Replies to your queries will appear on this page. ◄

Public Service Drugs

Some may remember the sled dogs mushing the life-saving serum to Nome, but few will remember that the material itself was furnished free by the manufacturer to meet a public emergency.

All of the ethical drug manufacturers have on their lists one or more drugs which are of use only to a limited few. Fortunately, there is no mass market for botulism antitoxin, antirabies serum, or actinomycin D, but these are on hand for use when needed. Such drugs are known to the trade as public service drugs and are provided after great cost of development at or below cost or free by the manufacturer, who in many instances also pays the cost of emergency transportation.

Recently marketed drugs of this sort range from idoxuridine, a compound useful in treatment of the virus-induced herpes keratitis to a compound useful in blocking excessive copper absorption in Wilson's disease or a dietary supplement useful in feeding infants who suffer from phenylketonuria.

It is a great credit to the pharmaceutical industry that these products in limited demand are made available. There is more involved here than the loss-leader technic or a bid for prestige. Whatever the cynics may say, we believe that what is really involved is responsibility. The companies feel it is their duty to serve the public and the medical profession in this way. This is something to remember during the present testing period for the industry.—Reprinted from *The New York Journal of Medicine,* Dec. 15, 1963.

LABORATORY MEDICINE

This page reviews established or relatively new but reliable laboratory procedures for physicians in general. It is not designed for specialists and laboratory personnel who would desire more technical information.

Alkaline Phosphatase Stain for Leukocytes

WEI-PING LOH, M.D.*
Gary

NORMAL GRANULOCYTES are known to contain alkaline phosphatase enzyme in their cytoplasm. The demonstration and semi-quantitative evaluation of this enzyme has offered considerable diagnostic significance in hematology. The alkaline phosphatase staining procedure is a useful tool in the diagnosis and differentiation of many clinical conditions.

Principle and Methods

Several staining technics are available and all depend upon the enzymatic decomposition of organic phosphates with the deposition of a colored precipitate at an optimal pH of 9.5 or 9.7. In the old Gomori technic, the precipitate is black. In the newer Azo-dye technics, naphthol is liberated from an alpha-naphthol phosphate by the enzyme and is then coupled with a diazotized amine dye to form a red precipitate. Details in the naphthol AS-BI phosphate technic are as follows:

1. Thin blood smears are prepared from a patient as for routine differential counts. Capillary blood or venous blood with heparin is used. EDTA should be avoided because of its inhibitory effect on the alkaline phosphatase activity. Positive control blood smears are prepared from an obstetric patient during the first 24 hours after delivery or from a newborn infant.

2. All smears are fixed in fresh 10% formalin in absolute methanol at 0 to -10C for 30 seconds. The smears are then washed in gently running tap water for 10 to 15 seconds and air-dried. Should a negative control smear be desired, one of the fixed smears may be inactivated by immersion in boiling water for one minute.

3. The dried smears are then placed in an incubation mixture for 10 minutes at room temperature. The incubation mixture is prepared as follows:

Dissolve 5 mg. naphthol AS-BI phosphate in 0.2 to 0.3 ml. of dimethylformamide (measure with a tuberculin syringe). Add 60 ml. 0.05 M 2-amino-2-methyl-1, 3 propanediol buffer (pH. 9.75).

(This is the working 0.05 M propanediol buffer).

Add 40 mg. Red Violet LB salt (diazotized 5-benzamido-4-chloro-2-toluidine). Shake vigorously and filter directly onto slides or into a Coplin jar.

4. After incubation, the slides are washed in running tap water for 10 to 15 seconds and dried.

5. The dried smears are then counterstained with Mayer's aqueous hematoxylin for three to eight minutes. The staining time varies with the quality and degree of ripeness of the solution. The counterstain is stable at room temperature for three to four months.

6. The counterstained smears are washed

* Chief Pathologist, Methodist Hospital of Gary; Asst. Professor of Pathology, Chicago Medical School.

in running tap water for 10 to 15 seconds and dried.

7. The stained slides are covered with a thin film of immersion oil or mounted in glycerol gelatin or Permount. No permanent type mounting medium is used if slides are to be discarded after scoring.

8. Scoring procedure: The enzyme activity may be described as increased or decreased, or the neutrophils may be graded as 0, 1+, 2+, 3+, or 4+. Usually 100 neutrophils are graded and the final score may then be from 0 to 400. Normally, the score is from 25 to 130, with the average being 30-60.

Applications

Lymphocytes, monocytes, eosinophils and platelets are generally unstained or negative for the alkaline phosphatase activity. The enzyme activity, in segmented and band form neutrophilic granulocytes as revealed by their staining intensity, varies with different clinical conditions which are summarized in the following table.

ALKALINE PHOSPHATASE STAIN FOR LEUKOCYTES*

Clinical Conditions (Paired where differential diagnosis involving the pair is frequently encountered)	*Alkaline Phosphatase Activity in Granulocytes* (Graded from 0 to ++++)
Normal adults	+
Obstetric patient at term or during the first 24 hours after delivery	+++ to ++++
Newborn baby	+++ to ++++
Chronic granulocytic leukemia	0
Leukemoid reaction due to infection CA, etc.	++ to ++++
Polycythemia vera	+ to +++
Secondary polycythemia	0 to ++
Acute lymphoblastic leukemia	++ to +++
Acute myeloblastic leukemia	0 to +
Aplastic anemia	0 to +
Myelofibrosis, thrombocythemia, metastatic CA, etc.	++ to +++
Pernicious anemia	0 to +
Multiple myeloma	+ to ++
Collagen diseases	+

Alkaline phosphatase activity:
0 equivalent to score of 0-25
+ equivalent to score of 26-100
++ equivalent to score of 101-200
+++ equivalent to score of 201-300
++++ equivalent to score of 301-400

* Reference: Kaplow, L. S.: Cytochemistry of Leukocyte Alkaline Phosphatase. **Am. J. of Clin. Path.** 39:439-449, 1963

TABLE I

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

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Jene R. Bennett, South Bend Dec. 31, 1964
Alvin J. Haley, M.D., Fort Wayne Dec. 31, 1965
Franklin F. Premuda, M.D., Hammond . . . Dec. 31, 1965
George M. Johnson, M.D., Richmond . . . Dec. 31, 1966
Irvin W. Wilkens, M.D., Indianapolis . . . Dec. 31, 1966
Necrologist: James B. Maple, M.D., 117 West Washington Street, Sullivan.

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Eradicate Tuberculosis

THE DEATH RATE for tuberculosis in the U. S. has fallen 68% in the past ten years, while the rate for newly reported active cases decreased by only 47%.

Drug therapy has been responsible for most of the improvement in mortality rates despite the discovery of drug-resistant strains of the tubercle bacillus.

It is thought that anti-tuberculosis drugs are effective enough at the present time to make possible eradication of the disease, if full advantage is taken of good medical treatment and proper control of active cases maintained to prevent new infections.

At the same time there is a possibility that, if full advantage is not taken of treatment and control measures, drug-resistant strains of the bacillus may continue to spread and that eventually the disease will exist in an endemic form resistant to eradication.

Drug-resistant strains are few enough in number today to make possible the isolation of all such cases, thus preventing new cases with resistant bacilli. At the same time if all drug-sensitive cases are vigorously treated, the goal of complete eradication of tuberculosis is a distinct possibility.

The important thing is that all these measures be taken now and prosecuted with vigor before the time that drug-resistant strains of the tubercle bacillus are commonplace and account for most of the active cases.

The Indiana State Medical Association has recognized the importance of a revived and renewed eradication campaign, and has been instrumental in organizing the "Coordinating Committee for the Eradication of Tuberculosis in Indiana." Representatives of 20 state organizations most interested in the problem comprise the committee.

A plan for eradication has been accomplished. It is based on essentials which consist of proper treatment of all active cases, vigorous search for new cases, lifetime follow-up of inactive cases and active efforts to further the combined programs in all parts of the state. Success of the effort will depend upon the wholehearted cooperation of every physician in the state. Anything less than our best will lessen the chances of eradication.

Many times in the past when a program was available for the eradication of a

disease and as it approached the final steps of eradication, the program was eradicated instead of the disease. The coordinated attack on tuberculosis is organized to avoid this contingency in the case of a most debilitating and expensive chronic disease. Apathy and a premature sense of victory are to be avoided.

Our Best Bargain—Medical Care

ALONG WITH EVERYTHING ELSE, the cost of medical care hit a new high in 1962 —$21.9 billion. This, however, is but 6.2% of all personal consumption expenditures, almost exactly the same percentage as was spent on recreation and only slightly higher than the total for alcohol and tobacco.

The ratio of medical care cost to personal consumption expenditures has risen slowly since 1948 from 4.3% to 6.2%. During most of the years the rise has been almost exactly 0.1%.

In five years the consumer price index (cost of living) has been elevated by 5%. During the same time, medical care cost has gone up by 14%, but is probably worth even more than that as compared to 1958, because of the advent of much more effective but more expensive drugs and technics. Medical care probably remains the best bargain we spend our money for.

Even with the more expensive drugs of modern times, the overall drug bill is easier now than it was five years ago. Drug expense is the only component of medical care expense which is lower now than in 1958—lower by 0.4%. Hospital room rates are up 29.8, physicians' fees up by 11.9, and the whole care package, as outlined above, is up 14.2.

Sources for these statistics and comparisons are the Department of Labor and the Department of Health, Education and Welfare as reported by the Health Insurance Institute.

The U. S. Department of HEW also reports that the average hospital stay for persons of all ages in the U. S. is 7.8 days with insurance paying part or all of the hospital bill and 9.6 days with no hospital insurance. This is for short-stay hospitals, and introduces a new element in the hypothesis that hospital insurance induces patients to stay longer than they should.

In every year since 1940, the number of Americans protected by some type of medical insurance has increased, both in absolute numbers and in percentages of the total population. In 1962 the figures were more than 141,000,000 and 76%. Indiana percentage was 80.1.

All types of medical insurance increased in 1962, with major medical leading the pack with a plus of 12%. Medical insurance in people over 65 continues to increase faster than in people under 65. Total premium income in 1962 for medical insurance was $9.3 billion.

The disproportion between people covered by regular insurance companies and by Blue Cross-Blue Shield continues to increase. The year 1962 saw 60 million covered by Blue Cross-Blue Shield, 84 million covered by other insurance companies.

The Health Insurance Institute reports that "few industries in America have experienced the dynamic growth of the health insurance business." The steady and unprecedented increase in number of people covered, the varieties of protection, the larger benefits and the tailoring of policies to fit individual needs has been the result of American initiative. Today there are 339 regular health insurance companies licensed to do business in Indiana, besides two Blue Cross-Blue Shield plans and eight independent plans.

It would appear that Americans have decided that they want and need good medical care, that they are willing to pay for it, that they consider it a bargain and that they rely on health insurance to make it possible.

Check Those Records

(The following fictitious record was submitted to The Journal by Miss Patricia Gubi, of the record room staff of Parkview Hospital, Plymouth. It's purpose, besides entertaining you, is to stimulate all physicians to take more interest in completing their records.)

HISTORY

Family Name	First Name	Attending Physician	Room No.	Hosp. No.
Dr. I. M. Sickentired				Hosp. #63-26486948376970293847583928736

Information should be recorded on all positive and also relevant negative findings regarding present complaint; present illness; past, family and social histories; and inventory by systems.

DATE _____

Chief Complaint: These are the doctors of Anywhere Hospital, Anyplace, U.S.A. who are sick of dictating, have been sick of dictating and who will always be sick of dictating.
Present Illness: This disease started during training for these patients and will continue throughout their life.
Past History: The disease is quite difficult to diagnose but the complaints are numerous. They consist of excuses, pleas and begging. No cure is known.
Review of Systems: All essentially normal.

Taken By Chief Nagger

Signature of Intern or Attending Physician

PHYSICAL EXAMINATION

Family Name	First Name	Attending Physician	Room No.	Hosp. No.
Dr. I. M. Sickentired				

PHYSICAL FINDINGS

(In this examination the following must be covered: head, neck, chest, heart and blood vessels, abdomen, genitourinary organs, bones and joints, neuromuscular system, skin and lymph glands.)

DATE _____

Physical: Well developed, well nourished white male in chronic distress.
Head: Headaches from the thought of charts.
Eyes: Tired of reading charts.
Ears: Tired of hearing gripes from Medical Records.
Voice: Tired of dictating.
Chest, heart and lungs: Pains on thought of the Record Room.
Abdomen: Upset stomach.
Extremities: Arms—tired of writing.
Legs—tired of running.

Reflexes: Fast on the get-away.

Initial impression: 1. Chartitis.
2. Occupational neurosis (Writer's cramp).

Final diagnosis: Same.

Rx: 1. Dictate.
2. Sign (We like your autograph).
3. Final diagnosis (We like to keep the insurance companies happy).

Taken by Chief Nagger

Signature of Intern or Attending Physician

Editorial Notes . . .

The Humble Oil Company in a recent publication titled "Read That Label" emphasizes the importance of reading and heeding all the information that is supplied with insecticides and other agricultural chemicals. There is no use having federal and state dangerous-chemical labeling laws if the labels aren't read and the cautions are not observed. All such chemicals are necessary and if used properly are safe. In pointing out the necessity for bug and weed killers, Humble quotes Georg Borgstrom: "If all the food of the world—including surplus stores—were distributed equally and each human received identical quantities, we would all be malnourished."

The Educational Council for Foreign Medical Graduates (ECFMG) is the entity which examines graduates of foreign medical schools and certifies them for positions in American hospitals. The examinations test their medical knowledge and their ability to understand and communicate in English. In the past it has been the custom to issue non-renewable two-year temporary certificates if the candidate came within five points of a passing grade. Due to the fact that this policy created occasional misunderstandings and a few awkward situations, and due also to the fact that a high percentage of candidates (total of 12,097 in two years) have passed the examination, the ECFMG has announced that it will no longer issue the temporary certificate.

Medical school expenditures rose from $70.5 million in 1947-48 to $515 million in 1962-63, up 630%. Of the $515 million, 46.5% was for regular operating programs, and 40.1% for research. The regular program increased by 348% in the 15 year span and the research outlay increase was close to 1,100%. Student enrollment during the period was up 38%, according to the Health Information Foundation.

The estimate of new medical schools needed to maintain the present ratio of 143 physicians per 100,000 population in the U. S. has recently been brought up to date. If the old and new schools are approximately the same size as they are now, and if the population expands at the 1955-57 rate, 36 additional schools will be required by 1975. This sounds like a large order, and it is, but it will only maintain the present ratio if accomplished. It will not increase the supply of doctors.

Success in anti-viral chemotherapy is reported in an editorial in the January 11 issue of JAMA. During a smallpox epidemic in Madras, India, 1,100 contacts were given oral doses of methisazone. Three mild cases developed. Another group of 1,126 contacts received standard vaccination—78 cases developed, 12 of them fatal. Vaccination has always been partially ineffective in epidemics. Chemotherapy may be more effective here and in other viral diseases. R. L. Thompson of Indiana University is credited with one of the first studies in the effect of chemicals on vaccinia virus in vitro. His results, published in 1949 and 1952, indicated the advisability of further study.

Add one more to the non-medical uses of cobalt-60. Wood impregnated with a liquid plastic chemical and then irradiated with gamma rays from cobalt-60 still looks like wood and may be worked like wood, but is several times as hard, has a higher compressional strength, absorbs water much more slowly and has much improved static bending strength. Due to its relative non-absorbability of water, it does not warp or swell as much as natural wood. Improved function in all present uses for wood and great adaptability to new uses are foreseen.

Sixty percent of the non-institutionalized aging population are protected by some form of health insurance. Medical insurance protection is expanding faster in the over 65 group than among those younger than 65. Over 200 companies are actively enrolling oldsters by mass enrollments and by continuing group coverage at retirement. Four out of five workers covered by group policies issued during 1962 offered em-

ployees the right to retain their coverage upon retirement.

Knowledge of failures and negative results in medical research would prevent researchers traveling the same route and thereby save a lot of time and dollars. Most scientific journals hesitate to publish such results, but some announcement and record of negative results should be made. The Pharmaceutical Manufacturers Association has asked Congress to require publication of "failures" in the government's $900 million health research effort. Negative results are bad enough the first time: much worse when obtained on an experiment unknowingly repeated.

Quick action by the Pharmaceutical Manufacturers Association and Wyeth Laboratories has helped contain a vicious smallpox epidemic in the Himalayan country of Nepal. Five thousand cases with 1,000 deaths in the 109,000 city of Katmandu alerted the U. S. State Department just before Christmas. Wyeth sent 100,000 doses of special freeze-dried vaccine (no need for refrigeration) by air on the request of PMA. The vaccine was in Nepal within 48 hours. The American Medical Association later pointed out how modern jet air travel could spread the infection over the world if an infected person were aboard. The United States is woefully behind on smallpox immunization, and the AMA is campaigning for widespread re-immunization.

A coloring book for pediatric patients developed as a by-product of the publicity campaign to raise funds for Marion General Hospital. In handling the publicity for the 90 new beds to be added soon, Don and Edwin Cole devised a 32-page coloring book which may serve as an orientation medium before admission of a child to the hospital, as an entertainment and educational gadget in the hospital, and as a memento after returning home. Titled "Dr. Fun in the Hospital," the booklet may be obtained from Medicolor, Marion, Indiana, at 30c each, and at lower rates for orders over 100 copies.

The Commission on Drug Safety, under the chairmanship of Dr. Lowell Coggeshall, has met each month since its organization in August, 1962. The 14 authorities comprising the commission and more than 200 other experts have collaborated in outlining the problems of drug safety and have held numerous seminars to outline methods of investigation. Seventeen commission subcommittees have made a final report which will be published in March. Its mission having been fulfilled, the commission will be disbanded. Its functions will be assumed by a newly formed Drug Research Board, a permanent organization created by the National Academy of Sciences-National Research Council.

"Beating swords into plowshares" has gone modern. Armor plate from the dismantled battleship U.S.S. Indiana is being installed as a shield in the radiation research room of the University of Utah College of Medicine. Old steel (in this case 25-years-old) is better than new since the residual or background radiation of the metal is lost with age.

The Floyd County Medical Society advertises in favor of the private practice of medicine. A large attractive ad in the newspaper concisely outlines seven factual points about King-Anderson—seven points not heard about from the socializers. Emphasized is the fact that doctors support health care for the aged. Ten points are listed to show that voluntary health programs and Kerr-Mills are doing the job—much better than King-Anderson would—and at less expense. WRITE YOUR CONGRESSMAN TODAY. ◄

President's Page

I recently received the following letter which I feel is sufficiently important to devote my page to it this month in order that every member may know its contents.

I want to call your particular attention to the next to the last paragraph. The letter follows:



Doctor Donald E. Wood, President
INDIANA MEDICAL ASSOCIATION
6325 Guilford Avenue
Indianapolis, Indiana

Dear Doctor Wood:

There seems to be some wide misunderstanding among doctors as to their liability, if any, under the new Indiana Sales Tax Act. I wonder if you would be kind enough to circulate the following information, which is our understanding of the law as it applies to the medical profession, to your membership.

Doctors are not obliged to purchase a retail merchant certificate, but, as always, the Revenue Department is urging them to do so in the belief that it will simplify his purchasing of tax-exempt items. He may use his retail merchant certificate number to sign an exemption certificate with his supplier, who then has the necessary proof of the tax-exempt status.

The sale of drugs, medical and dental preparations and similar materials to be directly consumed in professional use by doctors and hospitals are specifically exempt under the old Gross Income Tax Act. Therefore, the sale by a wholesale vendor of these items to a doctor is tax-exempt. Sales to doctors of other supplies, equipment and materials are subject to the Retail Sales Act.

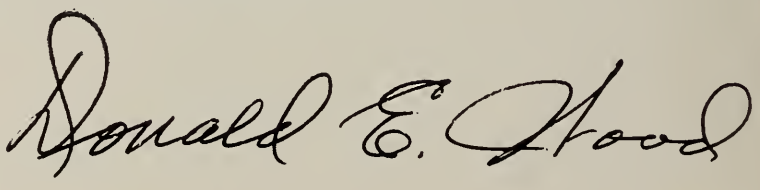
Drugs, medicine and other tangible personal property, which are personally administered by a doctor during the treatment of a patient are not the subject of a retail sale and, accordingly, are not taxable under the Sales Tax Act. Likewise, drugs and medicine and any other tangible personal property which can only be compounded by a doctor are not the subject of a retail sale.

On the other hand, any doctor who, for a separate charge, supplies or dispenses drugs, medicines or other tangible personal property in any manner other than the manner above-described is a retailer of such tangible personal property, and the tax applies at the time of the delivery of the tangible personal property to the consumer. This is interpreted to mean that when a patient comes to your office and buys medicine from the office girl and pays for it separately, there has been a taxable sale under the Act, and the Retail Sales Tax must be collected.

I should like to caution doctors about one more matter. There are indications that some of them have been attempting to purchase, under an exemption certificate, merchandise of a type not related to the profession. The exemption which is granted them under the Act applies solely to tangible personal property used in the profession.

The Department would be most appreciative if you could circulate this information. I am enclosing herewith two copies of Circular ST-20,* dated October 17, 1963, which states the Department's interpretation of the law as it applies to the medical profession.

Yours very truly,
James C. Courtney
Commissioner



STATE OF INDIANA

DEPARTMENT OF REVENUE

CIRCULAR ST-20*

TO: DOCTORS

SUBJECT: SALES TAX INFORMATION

Doctors are the consumers of the materials, supplies, or other items of tangible personal property which they use in performing their services.

The tax accordingly applies to the sale of tangible personal property to them, other than for such personal property specifically exempt by statute.

The sale of drugs, medical and dental preparations, and similar materials to be directly consumed in professional use by doctors and hospitals, are specifically exempt under Section 3 (a) of the Gross Income Tax Act; therefore, the sale by a wholesale vendor of these items to a doctor would be tax exempt.

Sale to doctors of other supplies, equipment, and materials would be subject to the Retail Sales Act. In order for a doctor to be able to purchase drugs, medical and dental preparations, and similar materials in a tax-exempt transaction, he must submit proof to the vendor of his tax-exempt status.

While any form of satisfactory proof can be used, the Revenue Department is urging physicians and surgeons to apply for and receive a Retail Merchants Certificate. This will simplify his purchasing of such tax-exempt items. He may use his Retail Certificate Number to sign an exemption certificate either individual or blanket with his supplier, who then has the necessary proof of the tax-exempt status.

If the doctor does not want to apply for and receive a Retail Merchants Certificate, he may furnish other form of proof to his supplier. Ordinarily this would be in the form of an exemption certificate stating clearly that it is being prepared by a doctor and is for the purchase of the items enumerated above.

Drugs, medicine, and other tangible personal property which are personally administered by a doctor or by an assistant under his direction during the treatment of a patient are not the subject of a retail sale. Likewise, drugs, and medicines, and any other tangible personal property which can only be compounded by a doctor or by an assistant under his direction are not the subject of a retail sale whether or not they are personally administered by such doctor or by an assistant under his direction.

Any doctor who for a separate charge supplies or dispenses drugs, medicines, or other tangible personal property in any manner other than the manner described above is a retailer of such tangible personal property and the tax applies at the time of delivery of the tangible personal property to the consumer.

James C. Courtney
Commissioner, Department of State Revenue

The Woman's Auxiliary

REPORTS TO ISMA

The House of Delegates of the Woman's Auxiliary to the Indiana State Medical Association will hold its 20th annual meeting on Wednesday, April 22 and Thursday, April 23 at the Terre Haute House, Terre Haute.

Mrs. Malachi C. Topping, chairman, assisted by Mrs. Hubert T. Goodman and the committees have planned the meeting allowing time for work and time for play.



Since this is our final meeting of the fiscal year, considerable time will be devoted to reports. The state officers and committee chairmen will report on the efforts made during the year to promote our program in the county auxiliaries. The county presidents will report on the activities of their auxiliaries during the year. As all work is done on the county level, these reports prove the most important phase of our meeting. The accomplishments of one county during the year often serve as an incentive and guide for another county in the following year.

Our National President, Mrs. C. Rodney Stoltz, will be our guest for the entire meeting. Mrs. Stoltz will speak at the banquet on Wednesday evening and those of us who have heard her are certain her speech will be informative and inspiring.

We will have a guest speaker for the luncheon meeting, Wednesday, April 22nd. Joseph R. Mallory, M.D., AMA National Speakers Bureau, will talk on current legislation and how it will affect the American people. He has a national reputation as a speaker on this subject and his talk will be timely.

The Hospitality Room will be open at all times and we are looking forward to a few quick games of bridge between business sessions.

We are planning for a full delegation from all auxiliaries and all members are welcome and urged to attend.

Zelda K. Sullivan



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Research in the Service of Medicine

Physician-Clergy Relationships Is Topic for Commission on Inter-Professional Relations

PHYSICIAN-CLERGY relationships and ways to create a better understanding between these two groups were topics for discussion at a recent meeting of the Commission on Inter-Professional Relations of the Indiana State Medical Association.

As an outgrowth of the AMA's recently established Department of Medicine and Religion, the commission, chaired by Doctor Paul Humphrey, Terre Haute, recognized that county medical societies throughout the nation were inaugurating physician-clergy programs.

Several Indiana county medical societies have invited clergymen in their areas to attend a society meeting, these societies have expressed the opinion that the meetings were mutually beneficial and worthwhile.

The AMA, in instituting the Department of Medicine and Religion, has pointed out that "The goal of American Medicine to attain the best of health conditions for all Americans envisions a degree of rapport with the clergy that will assure the best care and treatment for individual patients and the highest possible degree of consideration for the needs of patients' families."

The Indiana State Medical Association Commission on Inter-Professional Relations has endorsed this program, stipulating, however, that the initiation of such programs is entirely the prerogative of each component society.

Available for background information on such programs is a guide from AMA, which points up, step by step, the best procedures for a successful session. Available too, for such meetings is a film entitled "The One Who Heals," which has been produced by the AMA.

Requests for information and the film can be channeled through the headquarters office, Indiana State Medical Association, or by contacting: Rev. Dr. Paul B. McCleave, Director, Department of Medicine and Religion, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois. ◄

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Indiana State Medical Association
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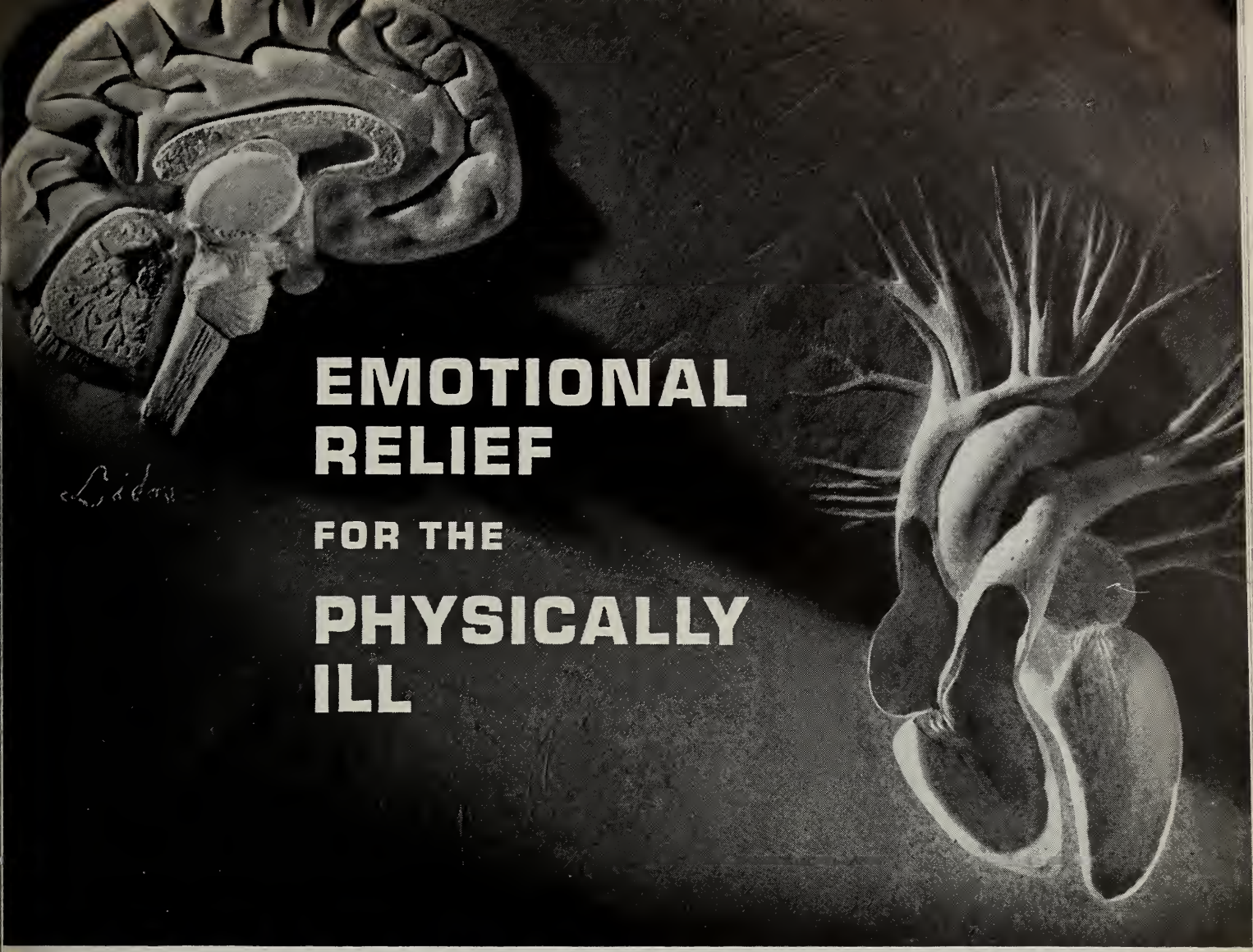
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The Coliseum Disaster

A Review and Evaluation of Disaster Preparedness

ALL INDIANA HOSPITALS make it a habit to conduct regular disaster drills. The value of these drills was put to the test on the night of October 31, when the box seats on the south side of the Coliseum erupted with tremendous force, hurling bodies and debris high into the air during the finale of the "Holiday on Ice" show.

The emergency medical work done by volunteer physicians, firemen, policemen, Red Cross-trained civilians, public and private ambulances, and by most of the hospitals in central Indiana has been rated as outstanding. Several hundred casualties were cared for promptly, and the mortality rate for those admitted to hospitals was low.

However, an actual disaster like this one shows too the weaknesses in the best laid disaster plans. Therefore a week later, the Indiana Hospital Association called together a meeting of representatives of hospitals, including those in neighboring counties, city and state police, fire department, Civil Defense, Red Cross, County Coroner, Public Health Officer, state and county medical societies, newspapers and radio stations to evaluate the community efficiency in handling this disaster.

Major Weaknesses

The major weaknesses and problems lay in poor communication and ill-defined lines of authority. This resulted in late notification or, in some cases, no official notification of the disaster to the hospitals — one hospital was notified by one of its doctors, one by the arrival of the second patient (the first casualty had neglected to state where he had received his injuries). This poor communication also caused the inequitable distribution of patients among the local hospitals and poor utilization of the hospital and medical resources of the community.

Methodist and St. Vincent's Hospitals received most of the patients. Fort Benjamin Harrison Hospital received only six patients (they had been notified by the Lawrence police); and the I.U. Medical Center received no casualties, although they were ready to receive patients. I.U. did provide blood for both Methodist and St. Vincent's and donors were instructed by these hospitals to go to the Medical Center. In addition, I.U. provided medical supplies and personnel to other hospitals. Marion County General Hospital, ready to handle a large number of casualties, saw only 38 patients and admitted half that number. Community Hospital did receive some casualties and admitted 12; St. Francis, in Beech Grove, saw 14 patients of whom four were admitted. The Veterans Administration Hospital played much the same role as I.U. Medical Center. They saw one patient, and then sent available personnel to General.

It is apparent that in disasters of this magnitude, the primary step must be the designation of some person or persons to "be in charge" at the scene. Nobody was officially placed in charge at the Coliseum, although as the disaster occurred on state property, the State Police had jurisdiction. It was difficult to control the people at the scene, Civil Defense and Red Cross personnel, doctors and others authorized and qualified to assist were indistinguishable from bystanders; some form of identification, such as vests or arm bands, should be readily available.

Radio communication between the scene of the disaster and all the area hospitals should be set up as soon as possible. Apart from aiding in a more equitable distribution of patients, it would also alleviate the confusion among the doctors and paramedical personnel as to where they should report. Radio communication would also make it possible to summon additional personnel as necessary. One doctor at the scene should be made responsible for sort-

Continued



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ing patients and assigning priorities.

In-Hospital Suggestions

The following suggestions have been offered by the various hospital staffs:

1. It would be helpful if emergency supplies could be packaged within the hospitals so that they may be transported to different areas of the hospital; a cart of emergency supplies should also be available in the x-ray laboratory.

2. Control check lists should be made for tetanus immunizations and other emergency items.

3. Patient tags should be larger to allow for clinical notes. All patients should be undressed for examination. Dry x-ray films should be clipped to patients and as soon as the x-ray diagnosis has been made it should be written on the envelope.

4. Each patient should be assigned a special student nurse to act as guide, coordinator and watcher of vital signs. Critical patients should have an M.D. in attendance at all times.

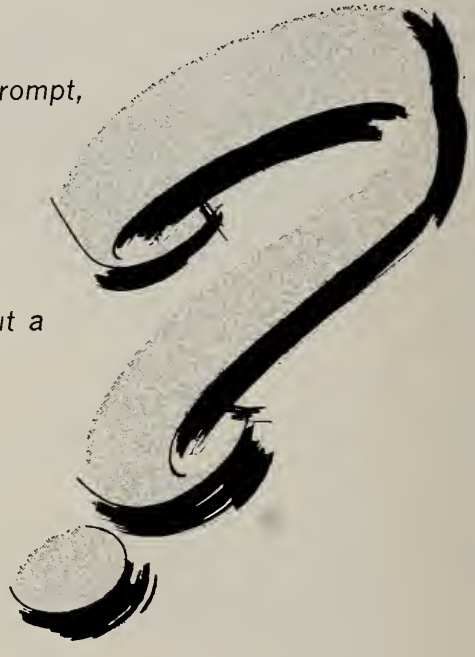
Two things that would bear consideration are the organization of intravenous therapy teams and a plan for one hospital to specialize in drawing blood. If the latter plan should be agreed upon, the public should be so informed, thus enabling donors to report to the correct hospital rather than arriving at their nearest hospital and being asked to report somewhere else.

It is beyond cavil that all the doctors, nurses, Red Cross and Civil Defense people and the hospitals did a magnificent job that harrowing night, but it is also true that we learn by our mistakes. It appears that what is needed is a community master plan for disaster, with all the hospitals standardizing their disaster plans so that hospitals and medical resources could be most effectively utilized and the postdisaster efforts of all agencies be completely coordinated.

While our disaster plans payed handsome dividends, there is still room for improvement. Let us adopt and test an overall community disaster plan, and pray that we never have to use it. ◄

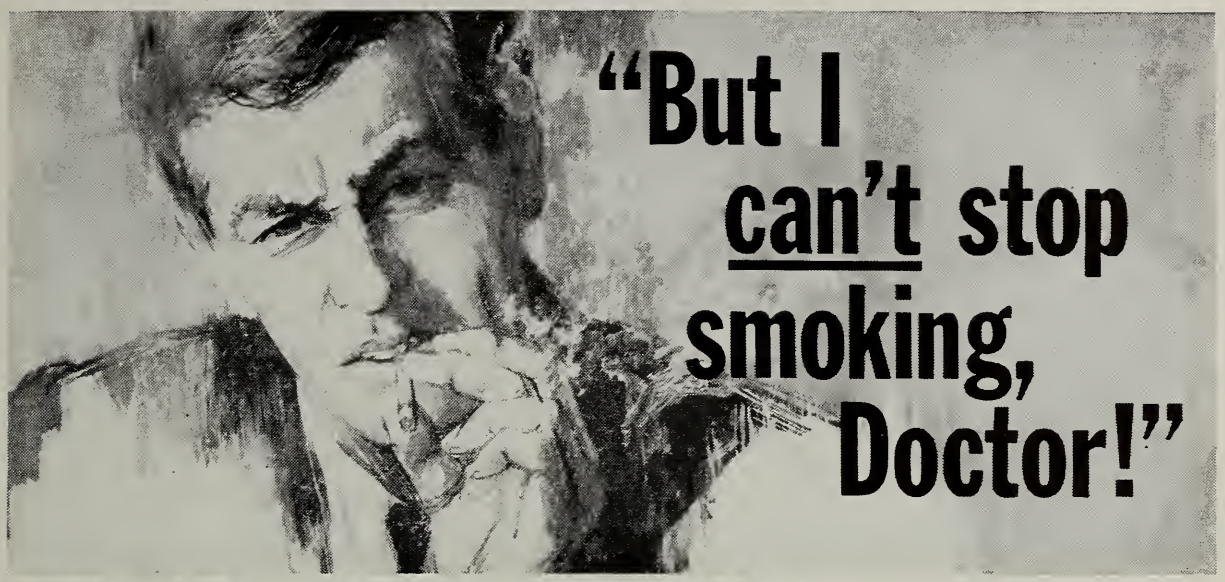
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- Encourage patient cooperation through pleasant taste.

Dosage and Administration: In order to obtain the maximum benefit, a NIKOBAN Pastille should be sucked slowly and taken according to the schedule below. Whenever possible a pastille should be taken after meals.

1st week: 1 pastille every 1 to 2 hours for a maximum of 12 pastilles daily. *2nd week:* 1 pastille every 3 hours. *3rd week:* 1 pastille every 4 hours. *4th week:* 1 pastille every 4 to 6 hours. *Thereafter* 1 pastille may be taken at infrequent intervals whenever necessary. In some instances there may at first be a slight astringent burr of the tongue and throat. This will usually disappear as treatment with NIKOBAN Pastilles progresses and is no cause for concern.

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References: 1. Goodman, L. S. and Gilman, A.: The Pharmacological Basis of Therapeutics, New York, Macmillan, 1960, Ed. 2, pp. 620-622; 2. Edmunds, C. W.: J. Pharmacol. and Exper. Therap., 1:27, 1909; 3. Hazard, R. and Savini, E. Gand., 92:471, 1963. 4. Dorsey, J. L.: Ann. Int. Med., 10:628, 1936; 5. Rasmussen, K. B.: Ugeskr.laeger, 118:222, 1956; 6. Ejrup, B.: Sven. lak. Tid., 53:2634, 1956; 7. Jochum, K. and Jost, F.: Munch. med. Wchnschr., 103:618, 1961; 8. Jost, F. and Jochum, K.: Med. Klin., 54:1049, 1959; 9. Smoking and Health, Summary and Report of the Royal College of Physicians of London on Smoking. New York, Pitman, 1962.

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Gleaned from the British Medical Journal

JACK W. HICKMAN, M.D.
Indianapolis

It has been recognized for some years that although lumbar sympathectomy may be helpful in improving skin temperature and promoting healing of ischemic leg ulcers, it does little, if anything, to improve intermittent claudication. Hopefully, more patients would be able to benefit through arterial grafting or thrombo-endarterectomy, but it is likely that a very large number of patients will not be suitable candidates for such potentially corrective procedures. Reid et al.[1] reported on a group of 65 patients who had a nerve-crushing procedure done between 1950 and 1960. The nerves to the gastrocnemius and soleus were crushed in this relatively simple procedure. One of the striking features of this series, besides the improvement in walking distance, is the fact that none of the 65 patients subsequently developed gangrene. Late failures of the procedure certainly did occur; however, the authors report initially good results in 85% and 50% success on long-term follow-up. They believe that this procedure will be helpful in selected cases where severe claudication is confined to the calf muscles of one leg. They feel that serious cardiac insufficiency, marked bilateral disease and questionable viability are contraindications to the procedure.

* * *

Another approach to the troublesome problem of duration of treatment of chronic pyelonephritis is presented by Hradcova.[2] The author states that in previous treatment regimes, such as short-term administration of antibiotics in acute flare-ups, permanent sterilization of the urine has been achieved in only approximately 10% of the patients. The study reported consists of 20 patients, all children, who were treated with a full dose of antibiotics during the initial acute episode and then given long-term administration of sulfa drugs over a period of three to 18 months. The patients have been followed for up to three years after the secession of therapy. On this regime, 11 children were clinically and bacteriologically cured and seven showed substantial improvement. This report coming with others gives further weight to the argument that routine treatment of urinary tract infections must be of longer duration than was originally considered necessary.

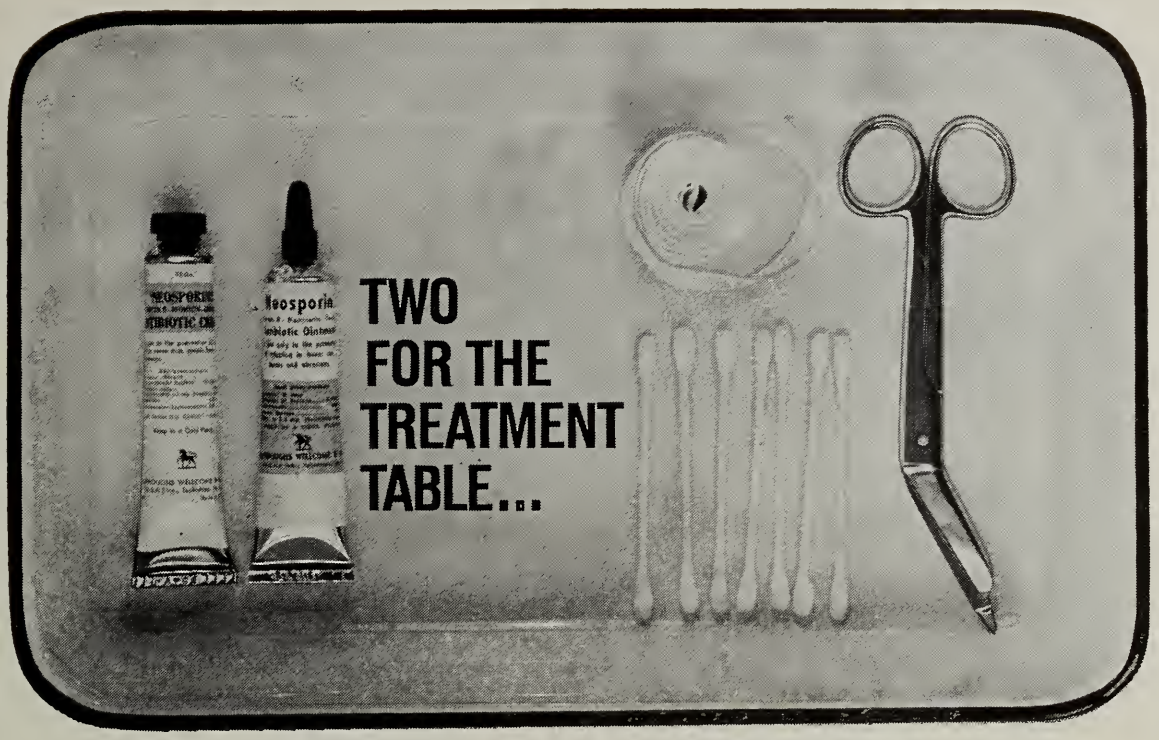
* * *

A number of complications following portacaval anastomosis procedures have been described, and the present report of Hearn and Paton[3] presents a new complication of this procedure. The authors describe two patients who developed diabetes mellitus after successful portacaval anastomoses. They admit that the development of diabetes mellitus could be coincidental; however, they are inclined to believe that the condition is somehow related to the surgical procedures. Another possibility of which they are cognizant is the question of hemochromatosis, but the evidence is strongly against this diagnosis. Both patients had moderately severe diabetes mellitus and both had subsequent admissions for diabetic pre-coma. It will be interesting to follow the literature for future reports of similar cases.

* * *

Anything presented by Sir George Pickering tends to make the rest of us sit up and take notice, and the President's Address which he delivered[4] is no exception. The sub-title of his address best summarizes the text, "A Plea for the Importance of Character in Medicine." Pickering covers his topic beautifully and describes the inherent dangers in the growth of specialization and the "scientific" approach to patients. He again asks his audience to not be replaced

Continued



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by a "machine of ultra-specialization." Certainly, there has always been more to the successful practice of medicine than a mere repetition and knowledge of scientific facts, and it is to be hoped that this will not change as years go by. How successfully pleas such as Pickering's will be is difficult to judge. It is hoped that people will take these warnings to heart and attempt to practice by such fine precepts. On the other hand, it is difficult, in medical education, to instill into fledgling physicians' character traits not inborn.

* * *

One of the rarest complications of smallpox vaccinations is reported by Cochran et al.[5] They present a report of a young child who suffered vaccinial osteitis. The child endured a rather prolonged course over a period of virtually a year. After the initial vaccination, a resultant bony abnormality occurred in the mandible. The child was treated with gamma globulin and fortunately has now recovered. Even though such complications are quite rare, it is well for them to be brought into the literature from time to time to keep us alert to the possibility.

* * *

With the present furor over the Surgeon General's report on tobacco and health, a number of studies such as the present paper[6] are likely to appear in the literature. All of us hope that future reports will be more encouraging than this one from the British Tuberculosis Association which studied the possible beneficial results of using Lobeline sulfate to help people stop smoking. Eighty-one subjects were studied, and this group was roughly divided between the treated group and the control group. The study was carried out for six weeks, and the data were analyzed at the end of the study. The subjects took Lobeline four times a day as compared with a group who took inert tablets for the same period of time. Unfortunately, it was concluded that the Lobeline tablets were no more effective than were the inert tablets. Furthermore, apparent decreases in the number of cigarettes smoked while on Lobeline were not present for any length of time.

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6. Smoking Deterrent Study—A Report From the Research Committee of the British Tuberculosis Association. *Brit. Med. J.* 5355: pp. 486-487. ◄

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Medicine At Law

DECISIONS AND OPINIONS

Highlights of recent court actions pertaining to health and medicine from *The Citation* prepared by the Law Division of AMA.

Medical Student Justified in Slapping Child Patient—A medical student was held to be justified in slapping a 23-month-old girl who bit his finger and refused to let go when he was examining her mouth. A judgment for the student was affirmed by the District of Columbia Court of Appeals.

The child was brought to the emergency room of a hospital for treatment of a lacerated tongue. While the medical student, who was employed as an "extern," was examining the girl's mouth, she bit his finger hard enough to cause blood to spurt from the finger, even though the student was wearing a rubber glove. The student shouted at the girl to no avail and twice tried unsuccessfully to force a tongue depressor into her mouth. Finally, he slapped her cheek and she released the finger. The wound was deep enough to touch the bone.

The trial court exonerated the student, saying that he may have acted rashly, but not maliciously, that the blow was not severe, and that the child was not injured. The appellate court held that an assault and battery was not proved, it accepted a rule that liability for using force to restrain or discipline a patient depends on whether the situation calls for the use of force, and, if so, whether the amount of force used and the manner in which it was applied were proper under the circumstances.

The court distinguished this case from one, *Burton v. Leftwich,* 123 So. 2d 766 (La., 1960), in which a physician was held liable for slapping the leg of a 4-year-old girl several times rather severely to make her lie still so that he could remove sutures from her toe. He was found to have used exceedingly bad judgment. The court concluded that the slap in the present case was more of a protective or defensive measure than a disciplinary measure.

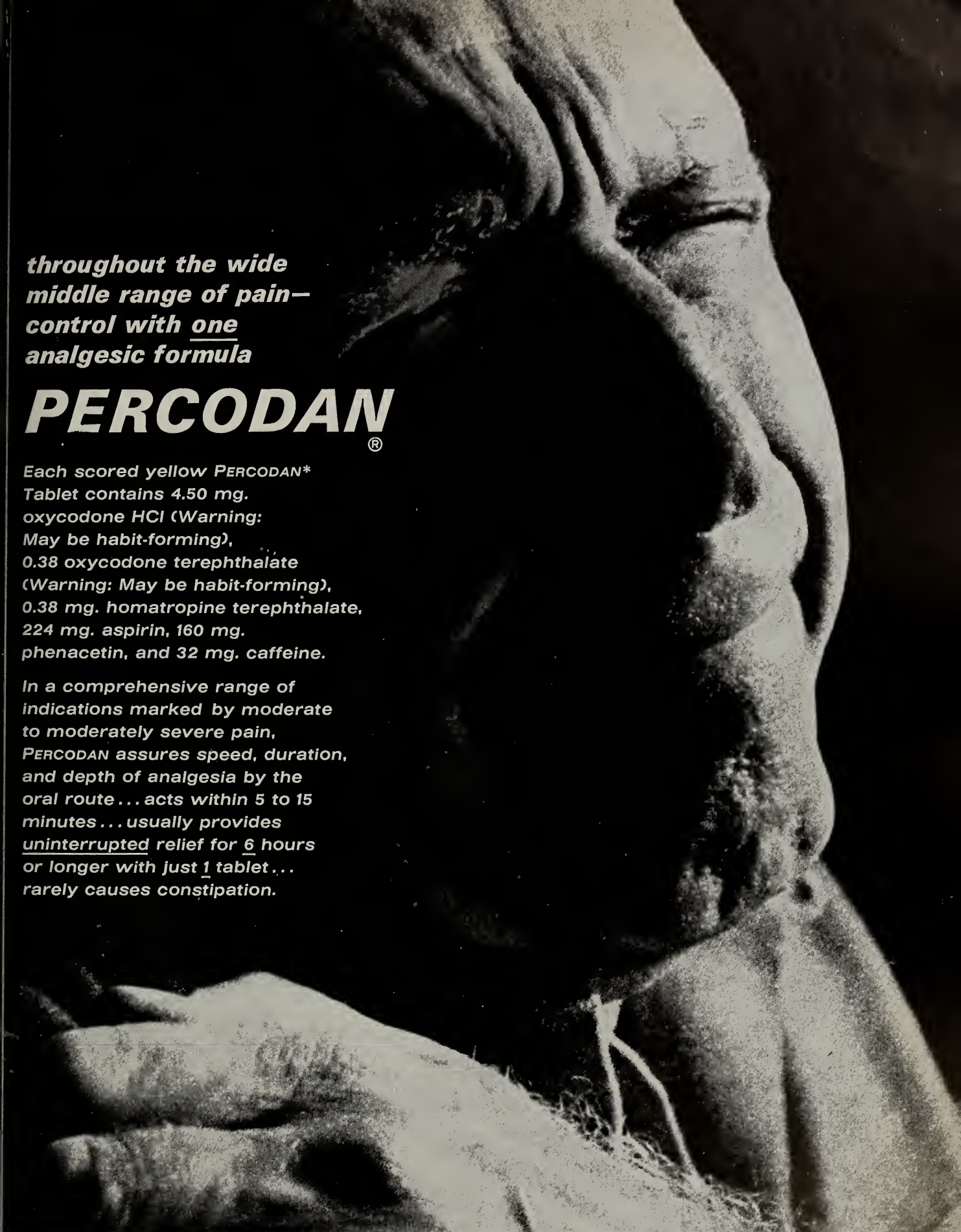
Mattocks v. Bell, 194 A. 2d 307 (D. of C., Oct. 16, 1963).

Citation Editor's Note: This decision does not go into the status of the medical student as an "extern." It appears to apply the same rules as would be applied to a licensed physician.

Evidence Sufficient to Establish Negligence of Doctor in Death of Patient—Evidence presented in a case charging the surgeon with negligence in the treatment of an emergency patient was sufficient to permit the jury to hold that the surgeon was negligent. A directed verdict in favor of the surgeon was, therefore, in error, the Court of Appeals of Kentucky held.

The patient was a Negro man who had been shot in the neck and was brought to the emergency room of a hospital at 1:00 a.m. Evidence presented would have permitted a jury to find that the surgeon called to treat him was intoxicated at the time. The jury could also have found that the surgeon did not furnish adequate medical care, in that he did not administer a blood transfusion and did not perform a tracheotomy. The evidence showed that the surgeon left the hospital to change his clothes and never returned to continue care for the patient. When the patient's condition grew worse, another doctor was called in. When he learned that the patient had been assigned to the surgeon he was unwilling to undertake the care of the patient unless the surgeon released him. The son of the pa-

Continued



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Continued

tient called the surgeon on the telephone and evidence would permit the jury to find that the surgeon, after a lengthy discussion, agreed to release the patient upon a promise of payment of $50.00. The second physician attempted to treat the patient but was unsuccessful. Death resulted from an embolism resulting from air escaping from the hole in his windpipe and getting into his blood.

The appellate court held that the evidence was sufficient to permit a jury to find that the surgeon was liable in the death of the patient because of negligence in his treatment and because of abandonment of the patient. Accordingly, it ruled that a directed verdict for the surgeon was improper and reversed the case in order to have a new trial.

Johnson v. Vaughn, (Ky. Ct. of App., June 7, 1963).

Doctor Liable for Misdiagnosis and Medical Mismanagement in Care of Child of Parents Having Rh-Factor Blood Incompatibility—A jury in a federal trial court returned a verdict against a pediatrician in a malpractice action charging mistake in diagnosis and medical mismanagement in the care of a child of parents with Rh-factor blood incompatibility. The appellate court held there was sufficient evidence to support the jury verdict.

The child was born of an Rh positive homozygous father and an Rh negative mother and is, therefore, Rh positive. Two days after her birth, she developed jaundice. On the basis of laboratory tests showing that her Rh-factor was negative, the pediatrician diagnosed the child's ailment as physiologic, rather than pathologic, jaundice; these test results were incorrect, a fact which the doctor could have discovered by reading the mother's chart. No van den Bergh's test was given; nor was any follow-up hemoglobin test given, although a second blood count, made four days after birth, showed a significant drop in hemoglobin. Shortly thereafter, the child was discharged from the hospital. Within a week she had a convulsion. During the first nine months of the child's life, her mother, by telephone calls and during office visits, advised the doctor of continuing jaundice and additional convulsions; one of such seizures occurred in the doctor's office in his presence. The doctor made no change in his diagnosis or his treatment. When the child was nine months old, a neurologist found she had kernicterus caused by pathologic jaundice.

There was medical testimony that the laboratory test showing the child as Rh negative was clearly wrong and should have been rerun; that, when the jaundice developed, a van den Bergh's test should have been run in view of the child's parents' Rh-factor blood incompatibility; and that there should have been a follow-up hemoglobin test when the second test showed a falling blood count. If these things had been done, a diagnosis of pathologic jaundice would have been required, and treatment, in the form of an exchange transfusion, given. Although the mortality rate in exchange transfusions may be high, the alternative is paralyzing brain damage and early death and it is, therefore, now, as it was when this case arose, the recognized medical practice to undertake the exchange transfusion. The appellate court said that this evidence was sufficient to support the jury's finding that the doctor was guilty of malpractice and the trial court's judgment based thereon was accordingly affirmed.

Price v. Neyland, 320 F.2d 674 (C.A., D. of C., May 2, 1963; rehearing denied, July 1, 1963). ◄

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Blue Cross—Blue Shield Protection For Federal Employees: Basic Programs

(One of a series prepared by Blue Cross-Blue Shield)

The Blue Cross-Blue Shield program for Federal employees has been in effect since 1960. It is a broad, comprehensive health benefit program, and presently more than 50,000 Federal employees and their dependents in Indiana are being served by our organization. Since these members live in all sections of the state, a review of both the basic program and the supplemental program should be of interest to all physicians and their assistants.

There is a high level and a low level basic program. The high level basic program will pay the full cost of a semi-private room, board and all other customary hospital services up to 120 days per admission. This program provides surgical and anesthesia indemnities according to a fee schedule which approximates our own Indiana preferred schedule. Also included are allowances for physician's visits in the hospital for non-surgical cases up to a maximum of 120 days per admission at $15.00 for the first day, $10.00 for the second, $5.00 for each of the next eight days and $4.00 for each day thereafter.

The basic low-level plan will pay the cost of semi-private room, board and other customary hospital services up to 30 days per admission. This plan provides surgical and anesthesia indemnities which are roughly equivalent to Indiana's standard schedule. Also included are allowances for physician's visits in the hospital for non-surgical cases up to 30 days per admission at $9.00 for the first day, $6.00 for the second day, and $3.00 for each day thereafter.

Both the high level and the low level basic program also provide allowances for diagnostic x-rays within 72 hours of an accident, either in the physician's office or in the outpatient department of a hospital.

Administration of claims under the basic program is the same as our other benefit programs. Both physicians and hospitals use our regular claim forms. Members participating in this program can be identified readily by the special Federal employee identification card and by the prefix "R" in the identification number. It is necessary to have the identification number, the enrollment code number and the *age of the patient* on all claims submitted. Claim forms should be mailed to the Indiana Blue Shield office in the usual manner.

Most Federal employees have their Federal employee identification cards, but if such a member does not have his card, ask him to obtain his identification number and enrollment code number from his employer.

The supplemental programs add to the basic programs in amount and kind. Detailed information about these programs will appear in next month's Blue Cross-Blue Shield article.

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ABSTRACTS

BOOK REVIEWS

HUMAN AGING: A BIOLOGICAL AND BEHAVIORAL STUDY

Birren, James E., and 22 other contributors from NIMH. *Public Health Service Publication No.* 986, Superintendent Documents, U.S. Government Printing Office, Washington 25, D.C. 328 pages. Price $3.00.

This book summarizes a very substantial, collaborative, multidisciplinary pilot study of 47 volunteer, physically healthy, socially dwelling and independent men, 65 to 91 years of age. It is unique in that it raises answers and many questions in the fields of psychiatry, social psychology, physiology and psychology concerning the *healthy* subject. The majority of research studies in the past have been based upon ailing institutionalized persons.

Although the report involves only a few carefully screened subjects, the intense, detailed collaborative team approach, using the latest research concepts and methods, makes it a very rich and rewarding study. Much raw data is included for those who may wish to draw some of their own conclusions. It is a well organized and well written report in a clear, concise and easily understood form.

There is something fascinating and interesting for all disciplines in this book. In fact you are in for quite a few encouragingly pleasant and unusual surprises about the healthy aged.

BYRON KILGORE, M.D.
Fort Wayne

THE EXOCRINE PANCREAS

Ciba Foundation Symposium, edited by A.de Reuck and M. Cameron. Little, Brown & Co., Boston, Mass., 1962. 390 pages, many illustrations, $11.50.

Several years ago there was a Ciba Symposium on insulin and glucagon, the *internal* secretions of the pancreas; the present volume is a companion to that effort. Following the usual format, this volume is very sturdy, attractive, well printed and well edited.

The latest results of electron microscopy are splendidly illustrated and thoroughly detailed. The research worker in this rather specialized area of medicine will undoubtedly study the fine print of the findings and the lively discussions appended to the end of each chapter. The teacher of gastroenterology is certain to find much that instructs. The section on the *abnormal* pancreas drew my own particular attention; the discussion on "The

Recent reports suggest...insulin and sulfonylureas may accelerate lipogenesis,[1-5]...serum "insulin" levels are often elevated in obese diabetics[2,3,6]...DBI (phenformin HCl) reduces high blood sugars, lowers elevated "insulin" levels, tends to reduce body weight toward normal.[1,3,7-9]

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In the ketoacidosis-resistant obese diabetic not amenable to diet alone, hypoglycemic DBI (phenformin HCl) appears to help avoid weight gain or reduce adiposity, factors which otherwise tend to make blood sugar control more difficult and to increase the likelihood of complications. However, in the ketoacidosis-prone diabetic, insulin is still the essential hypoglycemic agent.

Summary: Indicated in stable adult diabetes, sulfonylurea failures and unstable diabetes. Gastrointestinal side effects occurring more often at higher dosage levels abate promptly upon dosage reduction or temporary withdrawal. Occasionally an insulin-dependent patient will show "starvation" ketosis (acetonuria without hyperglycemia) which must be differentiated from "insulin-lack" ketosis, and treated accordingly. Use with caution in severe liver disease. Not recommended without insulin in acute complications (acidosis, coma, infections, gangrene, surgery). Consult product brochure for full information.

Bibliography: 1. Williams, R. H.: Textbook of Endocrinology, Ed. 3, Saunders, Philadelphia, 1962, p. 610. 2. Gordon, E. S.: Metabolism 11:819, 1962. 3. Grodsky, G. M. et al.: Metabolism 12:278, 1963. 4. Sadow, H. S.: Metabolism 12:333, 1963. 5. West, K. M. and Tophoj, E.: Metabolism 10:689, 1961. 6. Yalow, R. S. and Berson, S. A.: Diabetes 9:254, 1960. 7. Weller, C. et al.: Scientific Exhibit, A.M.A., June 1962. 8. Weller, C. et al.: Metabolism 11:1134, 1962. 9. Radding, R. S. et al.: Metabolism 11:404, 1962.

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Diagnostic Value of the Sweat Test in Cystic Fibrosis" was quite intriguing in its crisp and clear presentation.

Overall I cannot say that this volume either educated or stimulated me. Of course, this is a purely personal response on my part. Somehow or other, the discussants seemed to wander off into bypaths and have not taken the effort to gather their thoughts into a transmittable whole; I do hope that, when the next symposium on this tremendously important topic is held, this lamentable oversight (to me at least) will have been remedied.

ARNOLD LIEBERMAN, M.D.
New York, N. Y.

Abstracts From Various Literature, Prepared by AMA

URINARY RETENTION MANAGED WITHOUT URETHRAL CATHETERIZATION

A method of relieving urinary retention by the suprapubic insertion of a "Bardic Intracath" (an apparatus designed for venipuncture) is described. Advantages claimed for the method (as opposed to urethral catheterization) are freedom from infection, pain, bladder trauma, and, in particular, avoidance of interference with the normal channels of micturition. A modification of the Bardic Intracath known as the "Supracath" has been specially designed to improve the efficiency of the instrument for this particular purpose. Experience with the method described has shown that if the presenting episode of retention can be relieved without urethral catheterization, the ability to void will recover spontaneously in a high proportion of patients and the surgical treatment of the underlying bladder neck obstruction can then be performed at an optimum time. This is particularly valuable when urinary retention occurs as a complication of some other grave illness. The method is recommended as the initial choice of procedure in the relief of patients with acute urinary retention.

Cameron, E.: Urinary Retention Managed Without Urethral Catheterization, *Lancet* (London) 2:606 (Sept. 21), 1963.

VAGINAL CYTOLOGY IN "WELL WOMEN"

An analysis of 1,000 cases of clinical carcinoma showed that only 110 had previously sought advice for some other gynecological lesion, and it is assumed that unless cytology is offered to "well women," it will do little to control cancer of the cervix. Vaginal cytology was offered to all women in two general practices. Over 50% accepted the offer, and 15 positive smears were found in 2,358 cases. One patient refused further examination. Seven patients were treated for preinvasive and

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BOOKS

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seven for microinvasive tumors and all survived. The organizational methods used are described.

Way, S., Duran, F., Peberdy, M., Stefan, M.: Vaginal Cytology in "Well Women," *Lancet* (London) 2:264 (Sept. 21), 1963.

SUDDEN UNEXPECTED DEATH IN INFANCY AND MILK SENSITIVITY

The sudden, unexplained death of 33 infants (aged from one to 11 months) was investigated by determining titers of serum antibodies to cow's milk protein which were then compared with those obtained from 67 control infants. Four of the 33 infants had cardiac defects which of themselves could be lethal. In the remaining 29 infants, however, the lesions (minimal bronchopneumonia, or pulmonary congestion and edema) were not sufficient to have caused the infant's death. The study failed to establish any relationship between sudden death and the titer of milk antibodies in the serum of the infants. No differences existed between the antibody titers of the infants who died and those of the controls. The authors now attempt to demonstrate milk antibodies fixed in the bronchial tissues by fluorescent antibody technics on frozen lung tissue from the infants of this series.

Coe, J. I., Peterson, R. D. A.: Sudden Unexpected Death in Infancy and Milk Sensitivity, *J. Lab. Clin. Med*: 62:477 (Sept.) 1963.

COMMON BULLOUS LESIONS IN THE NEWBORN PRESUMABLY SELF-INFLICTED IN UTERO

Bullous and vesicular lesions have been observed about the thumb, fingers, and radial aspect of the wrists and forearms of newborn infants. Since these lesions are observed at the delivery table, they are presumed to have occurred in utero. In the absence of similar lesions over the rest of the body, failure of new lesions to appear, sterile cultures, negative serological tests for syphilis, and negative family histories, the possibility of bullous-lesion diseases can be eliminated. It is presumed that these lesions are produced by the infant's sucking these areas of his skin in utero. Fifteen of these infants were observed with this type of condition over a 12-month period or one case in every 240 births. It would seem important to identify these lesions and establish their etiology so as to avoid unnecessary procedures and prevent undue concern on the part of the physician and parents.

Murphy, W. F., Langley, A. L.: Common Bullous Lesions in the Newborn Presumably Self-Inflicted in Utero, *Pediat.* 32:1099 (Dec.), 1963.

ARE POSTOPERATIVE NARCOTICS NECESSARY?

In a study of 600 patients, a program of management was directed toward avoiding the potential dangers of depressing respiratory reflexes and obscuring manifestations of shock (restlessness) with narcotics. Patients in genuine pain which could not be relieved by reassurance or other supportive measures were given narcotics as needed, but only in very small doses. The decision to give narcotics was made in all cases by the attending physician or resident, and never by the nursing staff. The patient was psychologically prepared preoperatively by assuring him that his incision would be securely closed, that some discomfort is a normal consequence of surgery, that early mobility and ventilatory motion are essential for rapid and safe convalescence, and that motion in the operative site will reduce overall discomfort and disability, despite the initial pain. A survey of the nursing and resident staff who cared for these patients showed that in most cases postoperative discomfort was not increased by restricting or withholding narcotics, and that in many cases the postoperative course was considered more trouble free than in patients who routinely received large doses of narcotics.

Roe, B. B.: Are Postoperative Narcotics Necessary? *Arch. Surg.* 87:912 (Dec.), 1963. ◄

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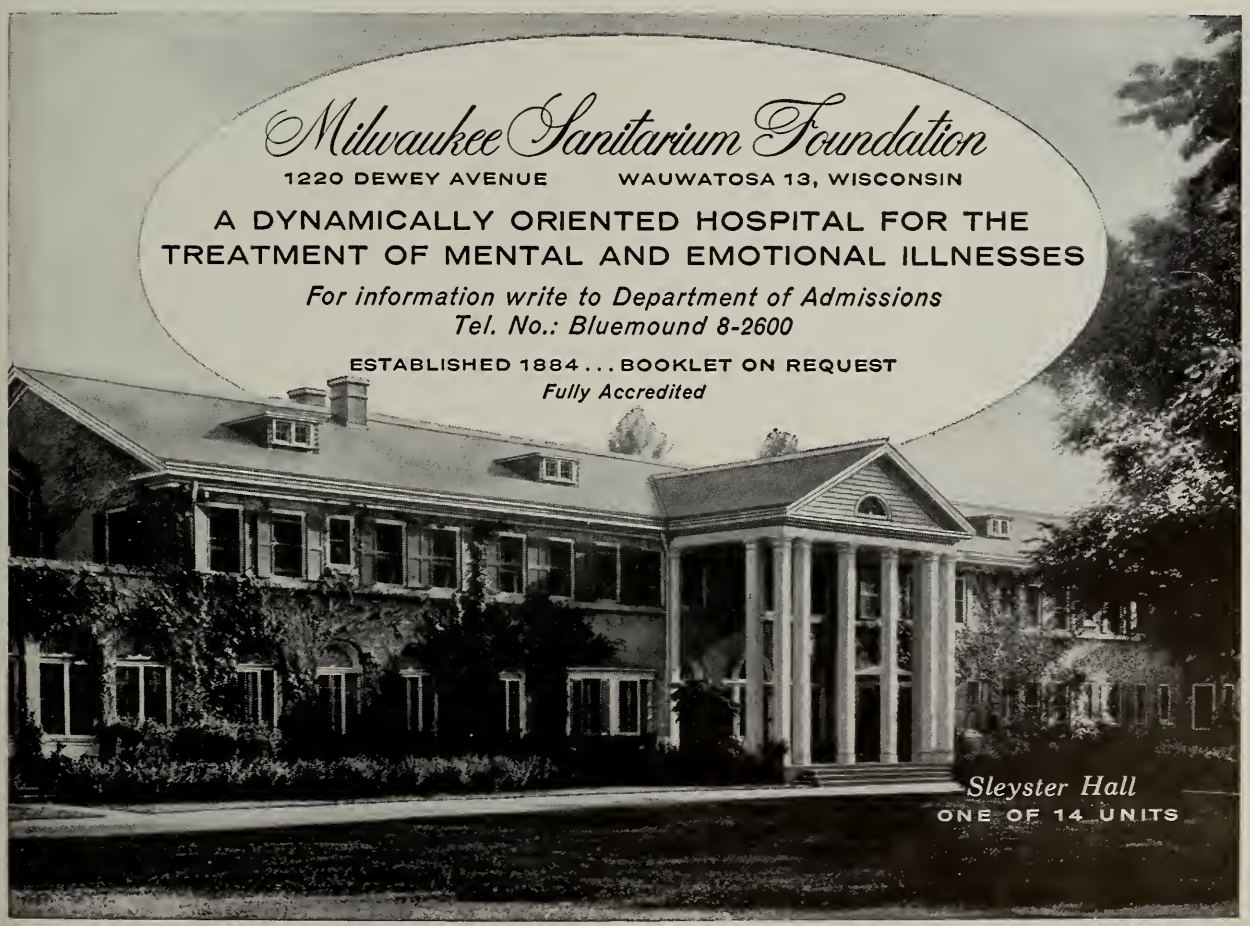
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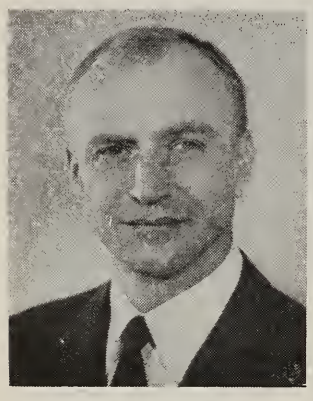




DR. NURNBERGER NAMED ACTING DEAN AT I.U. SCHOOL OF MEDICINE

Dr. John I. Nurnberger, Indianapolis psychiatrist, has been named acting dean of the I.U. School of Medicine.

Dr. Nurnberger is professor and chairman of the I.U. Department of Psychiatry and Director of the Institute of Psychiatric Research. A graduate of Loyola and Northwestern Universities, Dr. Nurnberger was a Research Fellow at the Institute of Cell Research and Genetics, Medical Nobel Institute, Stockholm.



He was formerly the Education Director, Director of Clinical Laboratories and Chief of the Cytochemical Research Laboratory at the Institute for Living, Hartford, Conn. and Assistant Clinical Professor of Medicine (Neurology) and Psychiatry at the Yale University Medical School.

Dr. Nurnberger has published numerous papers dealing with stress-induced cell chemical changes in the nervous system and other research problems. He is co-author of a monograph on endocrine disease and co-editor of an annual symposium volume on brain metabolism.

He has various awards and recognitions for his professional contributions, most recent of which was the Northwestern University Medical School's "Centennial Merit Award" for outstanding work in academic medicine, citing also his important cytochemical and biochemical studies in nitrogen metabolism.

U.S. Public Health Service Begins Radiation Field Study

The U. S. Public Health Service will conduct a field study in Indiana starting April 1st on the effect of radiation. The study will start with interviews with 250 patients in regard to diagnostic x-rays they have had.

"The Food You Eat and Heart Disease" Pamphlet Published

A revised and expanded edition of the Public Health Service pamphlet "The Food You Eat and Heart Disease" describes for laymen the association of diet and the cardiovascular diseases. To place the role of diet in prevention and treatment in realistic perspective, the 12-page pamphlet counteracts the popular misconceptions of diet as a cure-all while stressing its importance as specific therapy in some forms of heart disease. It is also offered as an aid to physicians and nurses in explaining heart disease and its dietary treatment to their patients.

The reader is cautioned that diet, like drugs and all special treatments, should be prescribed by a physician. This warning is followed by simple descriptions of the major cardiovascular diseases with discussions of how they are known to be affected by food and drink. The relationship between atherosclerosis, blood cholesterol level and dietary fats is explored, as is that between sodium and hypertension and the edema of congestive heart failure. Diet information is also given for other major heart conditions, such as rheumatic heart disease, stroke, and congenital heart disease. Good nutrition and weight control are emphasized as cardinal rules for all heart patients.

Single copies of "The Food You Eat and Heart Disease" are available without charge from the U.S. Public Health Service, Washington 25, D.C. Bulk copies for general distribution may be obtained through the Superintendent of Documents, Government Printing Office, Washington 25, D.C., at 10c per copy, $7.50 for 100 copies.

I.U. Alumnus at Parkland Hospital

Dr. Charles F. Gregory, the orthopedic surgeon who performed surgery to repair injuries to the right arm of Governor Connally suffered at the time President Kennedy was shot, graduated from the Indiana University School of Medicine in 1944.

In addition to the two wounds caused by the entry and exit of the bullet, there was also a comminuted fracture which occurred when the bullet passed through the governor's chest and struck his arm.

Dr. Gregory is professor and chairman of orthopedic surgery at Southwestern Medical School.

Dr. Taylor Moves to New Mexico

Dr. Cyril Taylor left Indiana University Medical Center early this month to begin the private practice of anesthesiology at St. Joseph's Hospital, Albuquerque, New Mexico.

Dr. Taylor, who has written many articles on anesthesia for *The Journal*, has been at the Medical Center for the past seven and a half years. English by birth, he received his M.D. degree from

University College Hospital Medical School in London in 1947.

Indiana Physicians Honored

Dr. Joseph Weber of Terre Haute and Dr. Roscoe E. Miller of Indianapolis were made Fellows of the American College of Radiology at the organization's annual meeting in Tucson on February 7.

Dr. Wallace D. Buchanan, South Bend, was installed chairman of the Board of Chancellors at the meeting and Dr. Harold C. Ochsner, Indianapolis, served as a member of the nominating committee.

Dr. Jones Elected Chairman

Dr. Eli S. Jones, of Hammond, has been elected chairman of the AMA Council on Occupational Health.

Dr. Jones has been a member of this Council since 1956 and previously was its vice-chairman. He has also served as a member of the AMA House of Delegates and as a member of the AMA Committee on General Practice.

He is a past president of the Industrial Medical Association. ◄

The Journal Welcomes New ISMA Members

Leonard J. Brooks, M.D., *Ob-Gyn*, Northwestern University, 1955. (Kosciusko)

Cloyd L. Dye, M.D., *Internal Medicine*, Indiana University, 1959. (Henry)

Herbert G. Erhart, M.D., *General Practice*, University of Louisville, 1962. (Dubois)

Darwood B. Hance, M.D., *Radiology*, University of Tennessee, 1956. (Wayne-Union)

Robert S. Kepner, M.D., *General Practice*, Temple University, 1959. (Madison)

Peter P. Mayock, M.D., *Internal Medicine*, Jefferson Medical College, 1947. (Wells)

James J. Rinehart, M.D., *Ob-Gyn*, Northwestern University, 1959. (Howard)

Dennis F. Rupel, M.D., *Psychiatry*, Northwestern University, 1956. (Elkhart)

Merrill W. Rusher, M.D., *Ob-Gyn*, University of Cincinnati, 1943. (Wells)

Roy A. L. Swanson, M.D., *General Practice*, University of Colorado, 1940. (Delaware-Blackford)

Stewart Wu, M.D., *General Surgery*, Bowman Gray School of Medicine, 1957. (Porter) ◄



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FUTURE MEETINGS, SEMINARS, COURSES

Spring Ophthalmologic Congress Scheduled for Virginia in April

The Spring Congress in Ophthalmology of the Gill Memorial Eye, Ear and Throat Hospital will be held at the Patrick Henry Hotel in Roanoke, Virginia, April 6 to 9.

Registration fee is $75.00. Complete information and a copy of the program may be obtained by addressing E. G. Gill, M.D., 711 S. Jefferson, Roanoke, Virginia.

American Rhinologic Society Announces Postgraduate Course

The American Rhinologic Society announces the sixth international postgraduate course on Reconstructive Surgery of the Nasal Septum and External Pyramid to be conducted at Cincinnati from May 5 to 15.

Drs. Lewis E. Morrison, Carl B. Sputh and Sydney L. Stevens of Indianapolis will be among the guest lecturers. As a part of the course three lectures will be given as a memorial to Dr. Samuel Iglauer, pioneer in rhinology in Cincinnati.

AMA Congress on Environmental Health Problems Set In Chicago

The AMA Congress on Environmental Health Problems will be held May 1 and 2 in Chicago at the Sheraton-Chicago Hotel.

The medical aspects of four problems will be considered—air pollution, water pollution, pesticides and radiation. This will be the first time that environmental health factors will be studied as a whole.

"The Sick Child in General Practice" is Symposium Topic

The Mound Park Hospital Foundation announces a postgraduate symposium in Pediatrics—The Sick Child in General Practice. This course will be held April 9 to 11, in the auditorium of the Mound Park Hospital and the clinics of the American Legion Hospital for Crippled Children.

Eighteen credit hours in Category 1 will be allowed by the American Academy of General Practice. For further information, contact M. A. Barton, M.D., Mound Park Hospital Foundation, Inc., St. Petersburg, Fla.

Seminar on Premature Care Set for April in Cincinnati

The Good Samaritan Hospital, Cincinnati, Ohio, has announced the second annual seminar on Premature Care to be held April 16, from 1:00 to 6:00 p.m. There are no registration fees but physicians planning to attend are requested to contact James J. Englert, M.D., Chairman, Premature Seminar, Good Samaritan Hospital, Cincinnati, Ohio.

Industrial Medical Association Plans April 13-16 Meeting

Members of ISMA are invited to attend the four-day meeting of the Industrial Medical Association at the Pittsburgh-Hilton Hotel, April 13 to 16. The scientific program is designed to be of interest to physicians in industrial practice, both full-time and part-time.

American Ob-Gyn Board Announces Oral and Clinical Exams

The next scheduled examination (Part II), oral and clinical, will be conducted for all candidates at the Edgewater Beach Hotel, Chicago, Illinois, April 27-May 2. Formal notice of the time of examination will be sent to each candidate in advance of the examination dates.

Current bulletins of the American Board of Obstetrics and Gynecology outlining the requirements for application may be obtained by writing to the secretary of the board, Robert L. Faulkner, M.D., 2105 Adelbert Road, Cleveland 6, Ohio. ◄

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Side Effects: Occasionally, mild salicylism may occur, but it responds readily to adjustment of dosage. Precaution: In the presence of severe renal impairment, care should be taken to avoid accumulation of salicylate and PABA. Contraindicated: An hypersensitivity to any component.

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Deaths

John Ditmars VanNuys, M.D. (1907-1964)

During his 17 years as its dean, the Indiana University School of Medicine rose to national and international prominence, recognized as a leader in the trilogy of medical education, medical service in the teaching hospitals, and in basic and clinical medical research.

Most noteworthy of the accomplishments of the period was consolidation of medical instruction on the University's Medical Center campus where an expanded, highly qualified teaching staff has been developed and a modern building to house the basic science departments has been erected.



His administration was marked by the spirit of mutual respect, understanding and cooperation existing between the school, its alumni, the medical profession at large, other health science agencies, and with other areas of the total university.

Few educational leaders are rewarded by their students year after year, with the respect and appreciation accorded Dr. VanNuys by the students in medicine. They knew him as a friend, interested in their problems and experiences.

Insistence by Dr. VanNuys that research facilities be provided for members of the teaching staff and available to those being sought for faculty appointments has been an important factor in bringing and holding outstanding teachers and researchers on the faculty.

Recognition of the medical school's obligation to provide postgraduate educational opportunities for physicians and specialists in practice, led Dr. VanNuys to the establishment of such a program, now serving more than 1,000 "students" each year.

Endowed with patience, courtesy, common sense and a saving sense of humor, Dr. VanNuys lived under pressures and responsibilities which would have been intolerable to one of lesser devotion and dedication.

W. Donald Close, M.D.

Maurice Gross, M.D.

Dr. Maurice Gross, native of Hendricks County, died Jan. 7 in Lawrence, Kansas where he was employed as assistant head of health service at Kansas University. He was 61.

Dr. Gross was graduated from the I. U. School of Medicine in 1928. He was a general practitioner at Ladoga for many years, leaving Indiana in 1947 to affiliate with the health service in Kansas.

Norris E. Harold, M.D.

Dr. Norris E. Harold, a retired general practitioner who made house calls on a bicycle at the turn of the century, died Dec. 29 at his Indianapolis home. He was 92 years old.

Dr. Harold, born at Tonganoxie, Kas., was graduated from the Physio-Medical College of Indianapolis in 1896, taught there briefly and practiced a short time at Westfield before starting a 60-year practice in Indianapolis.

He also called on patients by horse and buggy in his long career in medicine. In 1949 he quit private practice and was on the staff of the Indianapolis Industrial Clinic five years. He was on the staff of Methodist Hospital, a member of the ISMA 50-Year Club and the Marion County Medical Society.

William H. Hillman, M.D.

Dr. William H. Hillman, 89, a South Bend physician for more than 50 years, died Dec. 25 in a nursing home after a long illness.

Dr. Hillman, who retired from active practice a few years ago, began his practice in South Bend in 1910, after graduation from the University of Michigan Medical School. He was a member of the ISMA 50-Year Club and the St. Joseph County Medical Society.

Reid L. Keenan, M.D.

Dr. Reid L. Keenan, orthopedic surgeon who served at three Indianapolis hospitals before his retirement in 1962, died Jan. 17 in Methodist Hospital.

Dr. Keenan, 61, was on the staff at Methodist, Community and St. Vincent's Hospitals. After his retirement he served as a medical rating specialist for the Veterans Administration. He was a member of the Marion County Medical Society.

Francis J. Kleinman, M.D.

Dr. Francis J. Kleinman, Porter County physician for 47 years, died Jan. 5 in a Rochester, Minn., hospital. He was 76.

Dr. Kleinman, a member of the ISMA 50-Year Club and the Porter County Medical Society, was Hebron's only practicing physician. He served on the staffs of the Porter County Memorial Hospital and Methodist and Mercy Hospitals at Gary.

George May, M.D.

Dr. George A. May, 60, a practicing physician and surgeon at Madison for more than 30 years, died Jan. 9 at his home.

Dr. May went to Madison in 1931, after graduation from the University of Louisville. He was a veteran of World War II, having served in the Army for many months of combat action in the African and Mediterranean areas. He was a member of the Jefferson-Switzerland County Medical Society.

Louis H. Segar, M.D.

Dr. Louis H. Segar, retired Indianapolis physician, died Dec. 28 after a long illness.

Dr. Segar, 73, was one of the first Indiana doctors to specialize in children's diseases. He practiced in Indianapolis for more than 50 years and taught pediatrics at the I. U. School of Medicine for 30 years. He was graduated from the I. U. School of Medicine in 1912, and retired 10 years ago. He was a member of the Marion County Medical Society and the ISMA 50-Year Club.

William F. Walker, M.D.

Dr. William F. Walker, a Welborn Clinic specialist in internal medicine, died Jan. 1 at Holmes Hospital in Cincinnati. He was 34.

Dr. Walker joined the clinic in 1957. He was graduated from Duke University Medical School in 1950, took specialist training in internal medicine at Cincinnati General Hospital and was an Air Force medical officer in Japan. He was a member of the Vanderburgh County Medical Society. ◄

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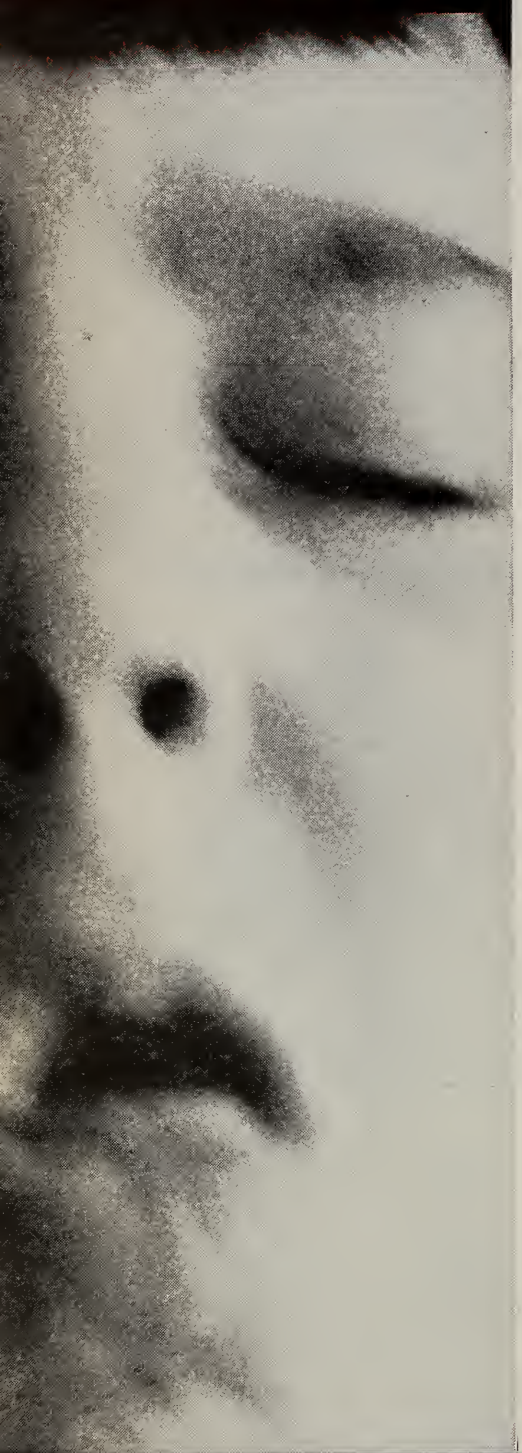
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County, District News

Ninth District

Dr. Edward M. Humphrey, Covington, has been elected president of the Ninth District Medical Society. Dr. Peter Petrich, Attica, will serve as secretary-treasurer and the district meeting will be held May 21 at Attica.

Adams

The newly elected president of Adams County is Dr. Robert Boze, Berne. Dr. John E. Doan, Decatur, will serve as secretary-treasurer.

Cass

Dr. Frank Teague, Indianapolis orthopedic surgeon, discussed and demonstrated various Swiss-made orthopedic devices before the February 3 meeting of the Cass County Medical Society. There were 46 members present.

Clark

Dr. William Clark, Jeffersonville, is the Clark County Medical Society's new president; Dr. David H. Jones, vice-president and Dr. Thomas Corrao, secretary-treasurer. Drs. Joseph Carr and Claude Meyer will serve as delegate and alternate, respectively.

Clay

The organization of a full-time county health department was the main topic of discussion at the Jan. 21 meeting of the Clay County Medical Society. Dr. Verne K. Harvey was speaker.

Daviess-Martin

Drs. V. J. Chattin and C. Philip Fox have been re-elected president and secretary-treasurer, respectively, of the Daviess-Martin County Medical Society. Other newly elected officers are Drs. Jack McKittrick, vice-president; R. H. Rang and E. B. Lett, delegates and C. Philip Fox and R. E. Chattin, alternates.

Elkhart

Dr. Ralph Ganser spoke on "Neurosurgery of the Ear" at the Feb. 6 meeting of the Elkhart County Medical Society.

Floyd

"Electrolytes and the EKG" was the topic of Dr. M. M. Best when he spoke before the Jan. 10 meeting of the Floyd County Medical Society.

Gibson

Elected new officers of the Gibson County Medical Society are Drs. R. E. Weitzel, president; W. R. Wells, secretary-treasurer; J. F. Peck, delegate and R. G. Geick, alternate.

Grant

The Grant County Medical Society has elected the following as new officers: Drs. M. Arthur Grant, president; John Rhorer, vice-president; Eugene S. Rifner, secretary-treasurer; Robert Brown, delegate and Lester Renbarger, alternate.

Greene

Drs. Robert Moses and H. G. Retman have been re-elected president and secretary-treasurer, respectively, of the Greene County Medical Society. Other officers include Drs. Kenneth Broshears, vice-president; Sam Rotman, delegate and Jerome Graf, alternate.

Hamilton

Dr. Hunter Soper discussed "Kidney Transplants" before the Jan. 14 meeting of the Hamilton County Medical Society.

Hancock

Elected officers of the Hancock County Medical Society are Drs. John H. Smith, president; Ted C. Kirby, vice-president; John J. Farrell, Jr., secretary-treasurer; Wayne Endicott, delegate and John H. Smith, alternate.

Hendricks

Dr. Donald Cheesman has been elected president of the Hendricks County Medical Society. Assisting him will be Drs. Mac Roller, vice-president; Carl Heinlein, secretary-treasurer; O. T. Scamahorn, delegate and Malcolm Scamahorn, alternate.

Henry

Newly elected president of the Henry County Medical Society is Dr. James N. Easter, New Castle. Dr. Phyllis Grant will serve as vice-president; Dr. Alfred Hollenberg, secretary-treasurer; Dr. Kenneth G. Hill, delegate and Dr. William C. Heilman, Jr., alternate.

Jackson-Jennings

Officers of the Jackson-Jennings County Medical Society for 1964 will be: Drs. I. S. Templeton, president; F. D. Ellis, vice-president; and Kenneth E. Bobb, secretary-treasurer.

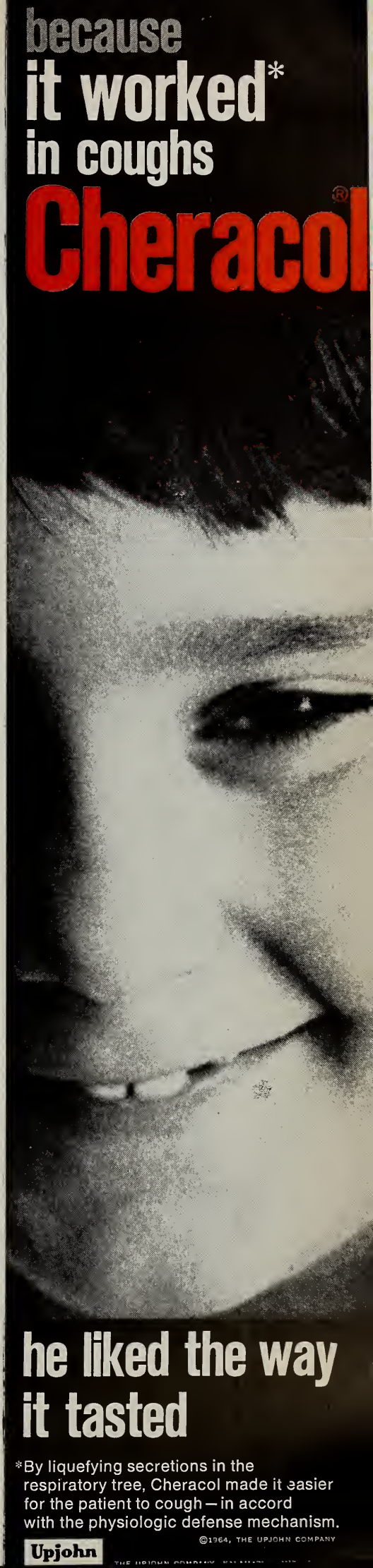
Jefferson-Switzerland

Dr. H. Shirmer Riley, Madison, has been elected president of the Jefferson-Switzerland County Medical Society. Other new officers are Drs. George F. Harris, vice-president; Ott B. McAtee, secretary; Robert O. Zink, delegate and William A. Shuck, alternate.

Johnson

Dr. Charles Link, Greenwood, is the new president of the Johnson County Medical Society and Dr. John M. Records the new secretary-treasurer.

Continued



COUNTY NEWS

Continued

LaGrange

The LaGrange County Medical Society has chosen Dr. H. F. Flannigan president; Dr. M. Reed Taylor, vice-president and Dr. L. R. Studebaker, secretary-treasurer.

LaPorte

The officers of the LaPorte County Medical Society for the year 1964 are: Drs. John F. Kerrigan, president; Edwin C. Mueller, vice-president and David P. Morton, secretary-treasurer.

Marshall

Dr. James N. Hampton is the newly elected president of the Marshall County Medical Society. Dr. J. Kent Guild will be vice-president and Dr. Ralph L. Rea, secretary-treasurer. Delegate will be Dr. Russell R. Hippensteel and alternate Dr. Donald W. Reed.

Montgomery

Newly elected officers of the Montgomery County Medical Society include Drs. S. J. Alexander, president; C. N. Thompson, vice-president; W. E. Shannon, secretary-treasurer; R. R. Eggers, delegate and J. M. Kirtley, alternate.

Owen-Monroe

Dr. W. C. Reed discussed his recent tour of Africa with the 76 members of the Owen-Monroe County Medical Society at its Jan. 16 meeting.

Porter

Dr. Leonard J. Green is the newly elected president of the Porter County Medical Society. Dr. Warren L. Kilmer will serve as secretary-treasurer; Dr. Ralph Eades, delegate and Dr. J. R. Krank, alternate.

Posey

New officers of the Posey County Medical Society include Drs. L. John Vogel, president; Paul Boren, vice-president; Herman Hirsch, secretary-treasurer; Frank Oliphant, delegate and L. John Vogel, alternate.

Randolph

Drs. C. R. Chambers, M. E. McClure and D. R. Sullivan are the new president, vice-president and secretary-treasurer, respectively, of the Randolph County Medical Society.

Shelby

Dr. Ralph Wilmore spoke on the role of the Ben-

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JAMES L. HAGLE, M.B.A.
Administrator
GRACE M. COLLET, Ph.D.
Clinical Psychologist

MARY JANE McCONAUGHEY, M.S.W.
Psychiatric Social Worker

PAULINE L. TOOILL, R.R.L.
Medical Record Librarian

ESTHER L. SIMPSON, R.N.
Director of Nurses

SHARON LaDOW, B.S., O.T.R.
Occupational Therapist

JAMES MYERS, B.S., M.Ed.
Recreational Therapist

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nett respirator in the treatment of pulmonary emphysema at the Feb. 5 meeting of the Shelby County Medical Society.

Spencer

The Spencer County Medical Society has elected the following officers: Drs. Michael O. Monar, president; John C. Glackman, Jr., secretary-treasurer; Dr. Monar, delegate and Dr. Glackman, alternate.

Steuben

"Infertility" was the topic of a speech by Dr. John C. Gould, Fort Wayne, before the Jan. 6 meeting of the Steuben County Medical Society.

Vigo

Dr. Melville E. CaJacob has been elected president of the Vigo County Medical Society. Other new officers are Drs. Hubert T. Goodman, secretary-treasurer; Stuart R. Combs, delegate and Thomas Conway, alternate.

White

The White County Medical Society has elected the following new officers: Drs. N. A. Hibner, president; W. V. Morris, vice-president and W. M. Dickerson, secretary-treasurer. ◄

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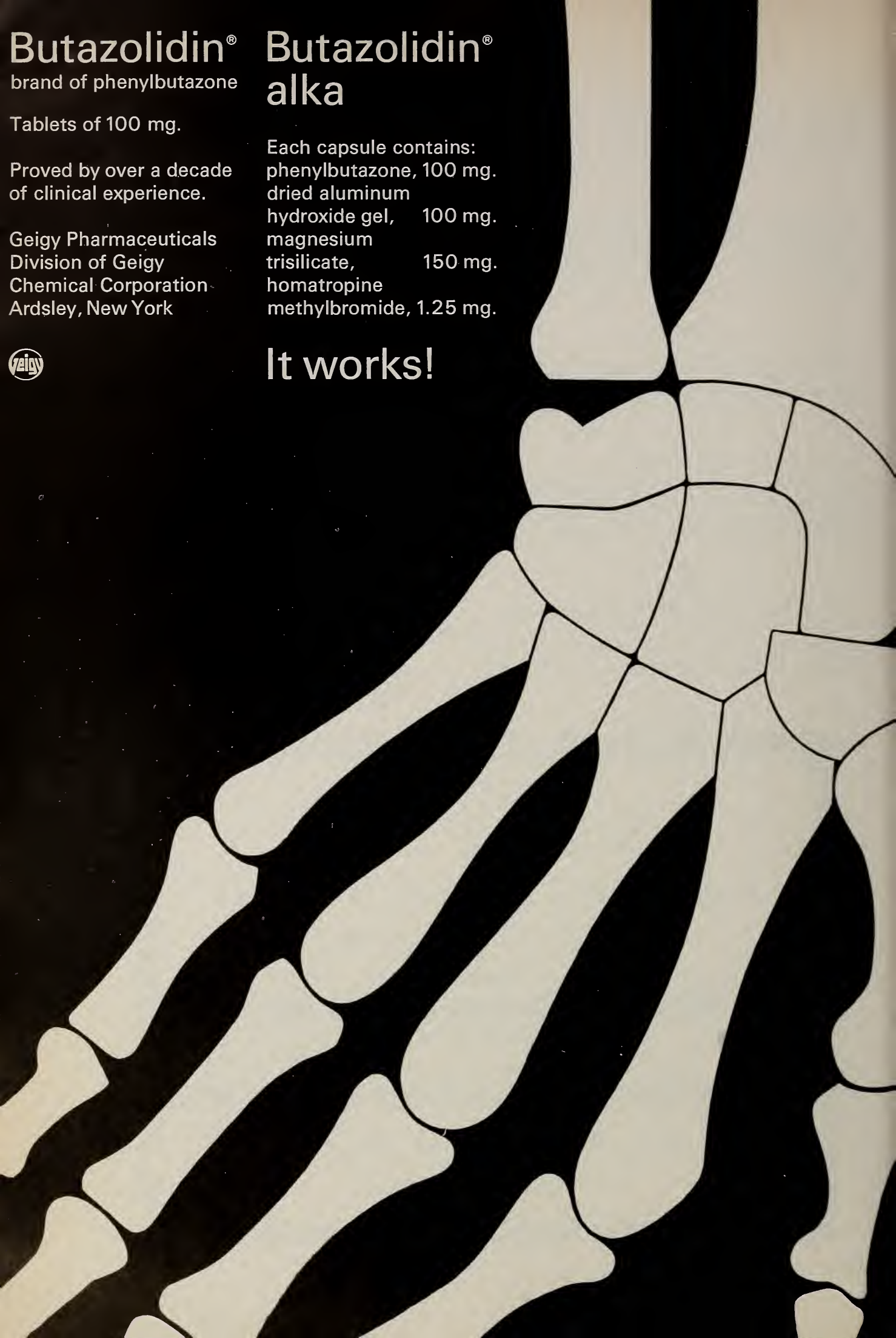
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INDIANA STATE BOARD OF HEALTH

MONTHLY REPORT — January, 1964

Disease	Jan. 1964	Dec. 1963	Nov. 1963	Jan. 1963	Jan. 1962
Animal Bites	340	339	649	235	283
Chickenpox	676	452	385	1132	531
Conjunctivitis	128	49	75	67	105
Diphtheria	0	0	4	0	0
Dysentery, Unspecified	113	65	56	533	66
Gonorrhea	250	293	279	Not Available	
Impetigo	96	54	169	67	119
Infectious Hepatitis	44	48	69	41	123
Infectious Mononucleosis	14	32	38	26	24
Influenza	1402	429	566	1314	5298
Measles (Rubeola-Rubella)	1249	464	299	654	359
Meningitis, Meningococcal	4	6	2	9	2
Meningitis, Other	8	5	6	4	4
Mumps	677	302	235	503	368
Pertussis	15	6	27	49	3
Pneumonia	237	210	131	245	203
Poliomyelitis	0	0	0	0	2
Streptococcal Infections	400	337	386	642	555
Syphilis					
Primary & Secondary	12	5	5	Not Available	
All Other Syphilis	94	94	120	Not Available	
Tinea Capitis	4	1	14	28	9
Tuberculosis (Active)	64	102	98	118	92



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Cobalt (as Cobaltaus Betaine Citrate)	0.1 mg.
Manganese (as Manganese Betaine Citrate)	1.0 mg.
Zinc (as Zinc Betaine Citrate)	1.25 mg.
Magnesium (as Magnesium Betaine Citrate)	6.0 mg.
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Vitamin B-12	6.0 mcg.
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Association News

EXECUTIVE COMMITTEE

January 11, 1964

Meeting called to order at 2:00 p.m.

Present: Ralph V. Everly, M.D., chairman George Willison, M.D., Don E. Wood, M.D., president, Joe M. Black, M.D., president-elect, Kenneth O. Neumann, M.D., chairman of Council, Ottis N. Olvey, M.D., assistant treasurer.

Frank B. Ramsey, M.D., editor of *The Journal*, Robert Hollowell, attorney, James A. Waggener, executive secretary.

Membership Report

Number of members as of December 31, 1962	4,340
1963 members as of December 31, 1963:	
Full dues paying	3,779
Residents and interns	149
Council remitted	44
Senior	338
Honorary	3
Military	58
Total 1963 members as of December 31, 1963	4,371
Number of members as of December 31, 1962	4,340
Gain over last year	31
Number of AMA members as of December 31, 1963	4,262
Total 1962 AMA members as of December 31, 1962	4,214
Gain over last year	48
1963 AMA members: Dues paying	3,637
Exempt, but active	594
	4,231
Number who have paid state dues but not AMA dues as of December 31, 1963	109

Headquarters Office

The state office had called to its attention the activities of the State Revenue Department in collection of sales tax from physicians under the new Sales Tax Act. In discussing this with the legal counsel, it was found the current ruling is in contradiction with a rule by the Gross Income Tax Division. A letter prepared by Mr. Hollowell and addressed to the State Revenue Department on this discrepancy was read and reviewed by the committee.

Building Matters

The chairman of the Building Committee presented his report concerning the use of the building by others than the association itself and on motion of Drs. Wood and Neumann, the report was approved and referred to the Council for concurrence.

A proposal for humidification of the building, the bid from W. L. Evans Company, for $1,035.00, was discussed and on motion of Drs. Wood and Neumann, this bid is to be presented to the Council with the recommendation that it be accepted.

Treasurer's Office

The treasurer made a recommendation concerning the transfer of funds of the association to the guaranteed loan account to be administered by the Indiana National Bank for student loans. He reported that inasmuch as this money was placed in escrow as a guaranty, and inasmuch as the bank was loaning $12.50 for each dollar placed in this account by the association, it should be considered whether all of the funds should be transferred at one time or only sufficient monies be transferred at a given time to guarantee loans approved by the Student Loan Committee, placing the balance on deposit to earn interest until such time as needed. This recommendation was approved on motion of Drs. Wood and Neumann.

Annual Convention, Indianapolis, October 14, 15 and 16, 1964

The secretary reported he had been requested to obtain information on the cost of an entertainment program for the 1964 convention. He was asked to investigate the cost of putting on a Gaslight Party for the members and for an estimate of the cost of entertaining those in attendance at a stage play in Clowes Hall. He reported he had received a quotation from Gaslight Club in Chicago for music and performers of $900.00, not including transportation and housing. Clowes Hall informed him they had not as yet booked a show for the date of October 14 but would advise if and when a show was booked and would give an estimate of the cost of entertaining those in attendance at the convention. This report was made for information only.

Legislation

The president reported on the problem facing the medical profession during 1964 in combating efforts to adopt the financing of care of the aged under the Social Security system. He called attention to the meeting which would be held on February 2nd to discuss the activities in this regard at the national level.

The chairman of the Council reported on a proposal which was currently being discussed by some of the health officers of districts to compel counties to establish full time county health departments.

Organization Matters

The secretary reported on a communication from the AMA calling attention to specific actions taken by the AMA House of Delegates at the Portland meeting which were to be referred to the constituent medical associations.

A notice of a public hearing was brought to the attention of the committee for a variance in zoning for the construction of another apartment building at the corner of 40th and Pennsylvania.

A report from Dr. Thomas Middleton of Bloomington suggested that the Executive Committee hold its next meeting in Bloomington, at which time they would be oriented on the new development of southern Indiana, which is expected to draw some 50,000 to 70,000 people to the area. Dr. Middleton pointed out that many facets of the public health program would be involved in this large expansion program. Following discussion, it was taken by consent that Dr. Middleton would be requested to appear at the next meeting of the Executive Committee to explain his ideas in more detail.

A letter from the Prudential Insurance Company requesting permission to appear before the Council of the association to discuss the variable and annuity insurance program under the Keogh Act was brought to the attention of the committee by the chairman of the Council. It was agreed this matter should be referred to the Commission on Medical Economics and Insurance for their investigation and review.

A letter from the State Board of Medical Registration and Examination inviting the association to be represented in a meeting of the board to discuss possible revisions in the registration procedures was read and on motion of Drs. Wood and Black, the secretary was instructed to represent the association at this meeting.

The request from the Hoosier State Press Association for the association to again take a full page ad in their annual convention publication was read and the request was approved on motion of Dr. Wood, taken by consent.

The request of the Indiana State Chamber of Commerce for the association to retain its membership was approved for payment on motion of Drs. Black and Wood.

A request from the Indiana League for Nursing, Inc., to list the association as a co-sponsor for a program they are planning on "Today's Child" was read. Action was deferred, pending further investigation of this request.

A letter from the Indiana Health Facilities Planning program director, outlining the part he requested the Indiana State Medical Association to play, was read and no action taken inasmuch as this question will be discussed by the Council at its next meeting.

A letter from Dr. Edwards to Henry Hineman, actuary for the Blue Cross-Blue Shield Plan, was read for the information of the committee.

A communication from the French Lick Springs Hotel asking the association to consider French Lick for its meeting in 1967 and 1968 was read and on motion of Drs. Neumann and Wood, the committee voted to recommend to the Council that the 1967 meeting be held in Indianapolis and leave the 1968 location to the discretion of the Council.

Two letters from the Indianapolis Medical Society requesting the Council to nominate Dr. Lowell Thomas and Dr. John Beeler as representatives on the Blue Shield Board were read and referred to the Council.

A request from the Indiana State Police and the Cornell Auto Crash Injury Research Program for the association to lend its support to a renewal of this program in Indiana was approved by consent.

New Business

Dr. Wood expressed the opinion that the association had perhaps overlooked, in past years, the valuable contribution past presidents had made and could make to the activities of the association. He pointed out that contrary to the policy established in many states, Indiana had seemingly forgotten its past presidents entirely, except to retain them as members of the House of Delegates. He also pointed out that past presidents, as a rule, had had at least 10 years of active participation in the business affairs of the association and were well versed in the programs. He felt they still had contributions which could be valuable to the association following their tenure in this office. Dr. Wood proposed that consideration might be given to retaining the president for a period of one year, following the close of his term, as a member of the Executive Committee and Council. This matter was reviewed and upon motion of Drs. Neumann and Wood, this is to be discussed before the Council with the recommendation that the proposal be submitted to the Constitution and Bylaws Commission for their consideration.

Dr. Neumann then presented a copy of a letter which had been received by their society from the Health Insurance Council concerning the establishment of review committees for handling insurance claims. Dr. Neumann felt there was some misunderstanding which might exist between the Health Insurance Council and the association. Upon his motion, taken by consent, this letter is to be referred to the Commission on Medical Economics and Insurance who will be requested to undertake a study and report its findings at the next annual meeting of the association.

Future Meetings

A folder giving information on the program of the 60th annual Congress on Medical Education in Chicago was presented and upon motion of Drs. Wood and Neumann, the chairman of the Commission on Medical Education was authorized to attend this meeting.

A letter to the executive secretary from the AMA requesting his attendance at a Mental Health Conference in Chicago on February 14th and 15th was read. His attendance was approved by consent.

There being no further business, the committee adjourned to meet again on call of the chairman, probably the latter part of February or the first of March. It was decided that the April meeting should be held at the Headquarters building on April 25th at 4:00 p.m. ◄

THE COUNCIL

January 12, 1964

The Council of the Indiana State Medical Association convened for its January meeting at 10:00 a.m., Sunday, January 12, 1964, in the headquarters office building, 3935 North Meridian Street, Indianapolis, with Dr. Kenneth O. Neumann, chairman, presiding.

Roll call showed the following present:

Councilors:

First District—P. J. V. Corcoran, Evansville
Gilbert H. Wilhelmus, Evansville, alternate
Second District—E. T. Edwards, Vincennes
Philip T. Holland, Bloomington, alternate

Third District—John M. Paris, New Albany (also AMA alternate delegate)
Donald M. Kerr, Bedford, alternate
Fourth District—Joe M. Black, Seymour (also president-elect)
Fifth District—V. Earle Wiseman, Greencastle
Sixth District—William R. Tindall, Shelbyville
Seventh District—Albert M. Donato, Indianapolis
Charles A. Jones, Franklin, alternate
Eighth District—Donald R. Taylor, Muncie
Paul Sparks, Winchester, alternate
Ninth District—Kenneth O. Neumann, Lafayette
Tenth District—Lowell H. Steen, Whiting
Eleventh District—E. S. Rifner, Van Buren
Twelfth District—Milton F. Popp, Fort Wayne
Thirteenth District—Jene R. Bennett, South Bend

Officers:

Don E. Wood, Indianapolis, president
Irvin W. Wilkens, Indianapolis, treasurer

Journal:

Frank B. Ramsey, Indianapolis, editor

Executive Committee:

Ralph V. Everly, Indianapolis, chairman
George W. Willison, Evansville, member

Guests:

Harold C. Ochsner, Indianapolis, AMA delegate
Guy A. Owsley, Hartford City, AMA delegate
Jack E. Shields, Brownstown, AMA delegate
John D. VanNuys, Indianapolis, dean, I. U. School of Medicine
A. C. Offutt, Indianapolis, State Health Commissioner
Lester D. Bibler, Indianapolis, AMA Trustee, and chairman, Student Loan Committee
Charles Fisch, Indianapolis, chairman, Commission on Convention Arrangements
D. S. Megenhardt, Indianapolis, member Professional Advisory Committee of Blue Cross
Robert Yoho, Ph.D. Indianapolis, State Board of Health

Staff:

Robert Hollowell, attorney
Robert J. Amick, field secretary
Howard Grindstaff, field secretary
Kenneth Bush, administrative assistant
J. A. Waggener, executive secretary

At the request of Dr. A. W. Cavins, alternate councilor, minutes of the meeting held October 14, 1963, were corrected to read: **On motion of Dr. Black, duly seconded, the present editor, Dr. Frank B. Ramsey, Indianapolis, and Drs. Lall G. Montgomery, Muncie, David A. Bickel, South Bend, and A. W. Cavins, Terre Haute, present associate editors, were re-elected for 1964.** With this correction **the minutes of the October 14 and 17, 1963 Council meetings, held at Indianapolis, were approved as printed in the December, 1963, Journal, on motion of Drs. Paris and Steen.**

For the information of new councilors, the chairman announced that mileage is allowed for attendance at Council meetings and meetings of special groups, such as the Council Liaison Committee with Blue Shield, and councilors should file their traveling expenses with the headquarters office on the form supplied by the office.

Reports of Councilors

District meetings were reported scheduled as follows during 1964:

First District—Evansville, May 7, 1964
Second District—Vincennes, _____,1964
Third District—Jeffersonville or New Albany, _____, 1964
Fourth District—Greensburg, _____, 1964
Fifth District—Brazil, _____, 1964
Sixth District—New Castle, May 14, 1964
Seventh District—Franklin, May 13, 1964
Eighth District—Anderson, June ____, 1964
Ninth District—Attica, May 21, 1964
Tenth District—Gary, _____, 1964
Eleventh District—Wabash, September 16, 1964
Twelfth District—Fort Wayne, May 20, 1964
Thirteenth District—Michigan City, September or October, 1964

Matters Referred to Council by Executive Committee

1. *Humidification of building.* **On motion of Drs. Black and Paris the Council approved installation of humidification controls in the headquarters building.** The proposal submitted by the W. L. Evans Company for $1,035.00, covering labor and materials, was accepted.

2. *State Board of Medical Registration and Examination.* The chairman read a letter which he had received from the State Board of Medical Registration and Examination which conveyed to the Council the fact that the board is studying possible changes or revisions regarding temporary medical permits and endorsements and inviting the Council to send a representative to the meeting to be held on January 14, 1964, for discussion of these matters. **It was taken by consent that the executive secretary should represent the Council at this meeting.**

The matter of acceptance of the National Licensing Board was discussed, the chairman calling attention to the fact that this cannot be delegated by Indiana law. It was the consensus that the new State Board favors acceptance of the National Board and there probably will be a revision on the Indiana law in the next legislative session. The secretary requested instruction as to what he should convey to the board on this subject.

On motion of Drs. Corcoran and Paris the Council approved "endorsement in principle of a well-developed, national, planned licensure."

3. *Use of headquarters building by other groups.* The following report, presented by Dr. Everly, chairman of the Building Committee, was approved by consent, on motion of Dr. Everly:

In accordance with the request of the Council, the Building Committee submits the following report concerning its recommendation on use of the building by other groups:

(1) That use of the building for meeting purposes by medical organizations, such as specialty groups, held during regular office hours, not necessitating additional

expense for personnel, shall be granted free of charge, provided it is not in conflict with meeting requirements of the Association.

(2) That such groups desiring to use the building outside of normal office hours shall be requested to pay the expense of maintaining personnel to close the building.

(3) Use of the building by non-medical groups should be discouraged.

(4) The cost of any food consumed by these groups will be at their expense.

4. *Locations for 1967 and 1968 conventions.* **On motion of Drs. Bennett and Taylor, the Council approved the Executive Committee's recommendation that the 1967 convention be held in Indianapolis.**

Action on selection of city for the 1968 convention was deferred. Set convention dates and places are:

1964—Indianapolis, October 13, 14 and 15, 1964
1965—Indianapolis, October 12, 13 and 14, 1965
1966—French Lick, October 10, 11, 12 and 13, 1966
1967—Indianapolis, October 10, 11 and 12, 1967

5. *Indiana Health Facilities Planning Program.* The chairman read a memorandum on "The Suggested Role of Indiana State Medical Association in the Indiana Health Facilities Planning Program." This was discussed by several Council members. **On motion of Dr. Edwards, seconded by many, the Association backed the present structure of the Indiana State Board of Health and voted that the request of the Indiana Health Facilities Planning organization be tabled.**

6. *Purchase of real estate.* **On motion of Drs. Black and Rifner, the Council voted to instruct the Building Committee to investigate the possibility of acquiring one or two pieces of property directly east of the headquarters office, with the idea of providing an access to the building other than the Meridian Street entrance, plus the fact that this additional land might be used for future expansion purposes.**

7. *Action of Sears Advisory Board.* The secretary explained that upon receipt of a notice that Sears was planning to start a new program of financing the construction of physician's offices and hospital factions, the president of the association had filed a protest with the American Medical Association and it is understood that the Sears Advisory Committee has reversed its decision and will not do this.

8. *Utilization of services of past presidents.* **By consent, the suggestion of the Executive Committee that the talents of the past presidents be utilized for one year following their term of office, by membership on the Executive Committee, or as a member of the Council, or in any designated position, was referred to the Commission on Constitution and Bylaws for its study and recommendation.**

9. **Payment of annual dues in the Indiana State Chamber of Commerce for 1964 in the amount of $1,000.00 was approved by the Council on motion of Drs. Steen and Rifner.**

Reports of Officers

DR. DONALD E. WOOD, president, reported that the Portland meeting of the AMA was a success and that the delegates and officers conducted themselves admirably. Dr. Wood also reported on his attendance at the meeting of all the accepted students for the Indiana University School of Medicine. He called attention to the meeting of county society representatives to be held in the association offices on February 2 and urged the councilors to in turn urge the counties in their districts to be represented.

The president reviewed the legislative matters before the Congress.

DR. JOE M. BLACK, president-elect, also spoke of the AMA meeting and of the tremendous job that the Indiana delegates are doing on the national level.

Dr. Black reported that he had attended the meeting at the university regarding graduates from the medical school and called attention to the fact that although some 160 students were graduated last year, the increase in membership in the Indiana State Medical Association for the year was less than 50. "It is my feeling, after attending this meeting, that perhaps our own Indiana Chamber of Commerce should do a better job of selling physicians to stay at home. When we realize that this is a state university and it is financed by state funds, I think we should go to work and try to keep our doctors at home."

DR. FRANK B. RAMSEY, editor of *The Journal: The Journal* has a new printer. The January issue will be the first one under the new contract. It is a contract that as nearly as we can tell will be more economical than the old one and we think that the printing will be as well done as previously. We have settled on a new way of binding *The Journal*, which is the same way that *Time, Newsweek*, and all the popular magazines are bound, so they will open out flat. That is more economical than our present way of doing it, and those two items together stand a chance of saving us about $4,000.00 in a year's time.

The advertising has not started to pick up yet. Last year we averaged 40 pages each issue and in January we have 30¼ pages. Of course we hope that we will get a pick-up on that later.

DR. IRVIN W. WILKENS, treasurer, presented financial statements showing the status of the various funds of the association, the operation status, and the total investments of the association as of December 31, 1963. He reported that as of January 10, 1964, the balance in the General Fund bank account was $18,780.94.

Dr. Wilkens also reported that $18,810.00 from dues apportionment in 1963 would be transferred from the General Fund to the Student Loan Fund, which is now being handled by the Indiana National Bank. This amount, plus the allotment of $40,000.00 by the House of Delegates, will bring the

fund, when multiplied by 12½, according to the plan, to approximately a quarter of a million dollars for loan to students.

Budget. Preparation of the association budget and distribution of the budget figures for the information of the Council and the members at large, were discussed by Drs. Corcoran, Wilkens, Wood, Rifner, Wilhelmus, Paris, Bennett, and Holland.

Dr. Holland moved that the same procedure be followed in regard to the budget as has been followed in the past. Motion duly seconded.

Following further discussion it was taken by consent that in the future each member of the Council will be notified in advance when the Executive Committee will review the budget, and the councilors may attend that meeting if they so desire. If possible, this meeting will be scheduled on Saturday evening, with the Council meeting on the following day. The approved budget is to be sent to the councilors who do not attend the meeting with the Executive Committee.

Dr. Holland's motion was put to vote and carried.

Copies of the budget for 1964 are to be sent to each councilor.

Delegates to the AMA: DRS. HAROLD C. OCHSNER, JACK E. SHIELDS, and GUY A. OWSLEY reported on actions taken by the AMA House of Delegates at the clinical meeting December 1-4, 1963, in Portland, Oregon. (For complete report, see pages 56 to 60, January, 1964, *Journal.*)

Following discussion, Dr. Bennett suggested that a letter be sent to the county medical societies by the AMA delegates following the national meetings, giving information on the actions taken by the AMA and indicating some of the things that the county societies should do at the local level in promoting some of the projects proposed by the AMA.

DR. LESTER D. BIBLER, AMA trustee, spoke on AMA matters and recommended that the Council go on record as supporting Dr. E. S. Jones of Hammond for the surgical representative on the AMA Commission on Medical Practices. He asked that the Council send a letter in Dr. Jones' behalf to the nominating committee of the AMA Board of Trustees, and **this action was approved by consent.**

Matters from Commissions and Committees

1. *Student Loan Committee*:

a. **On motion of Drs. Donato and Black, the Council concurred in the opinion of the Student Loan Committee that assistance to the AMA Medical Education Guaranteed Loan Program, by solicitation of financial support from Indiana industrial firms be deferred,** inasmuch as the state association is at this time in the process of setting up its own loan program through the Indiana National Bank. Mr. Lyman Smith, director of AMA-ERF, is to be written to this effect.

b. Dr. Bibler, chairman, and Mr. Hollowell, attorney, discussed the agreement which is to be entered into with the Indiana National Bank under which the new loan plan will operate. **The following amendment, to be inserted in the agreement for consideration of the Indiana National Bank, was approved on motion of Drs. Rifner and Taylor:**

> "Provided however that the total liability of the Indiana State Medical Association shall not exceed, but shall be limited to the amount of the capital reserve held and maintained under paragraph nine (9) of this agreement."

c. Dr. Bibler reported that the financial statement on the Student Loan lists $3,125.39 in delinquent accounts and outstanding loans of $36,835.35. The committee has an agreement with the bank that the bank will attempt to collect the delinquent accounts. As outstanding loans are collected, this money will automatically be deposited in the Student Loan Fund and will be invested in Certificates of Deposit.

The new student loan program was discussed by Drs. Wood, Paris and Rifner and Mr. Hollowell.

2. *1964 Annual Convention, Indianapolis, October 12 to 15, 1964.* Dr. Charles Fisch, chairman of the Commission on Convention Arrangements, presented the following tentative program for consideration of the Council:

Monday, October 12, 1964

	Executive Committee meeting Council meeting
Evening	Meeting of House of Delegates (not a dinner meeting)

Tuesday, October 13, 1964

Morning	Reference Committee meetings
Afternoon	Section meetings. (Sections will be responsible for arranging their own programs.)
Evening	Fireside Conferences, sponsored by Indiana Chapter of the American College of Chest Physicians.

Wednesday, October 14, 1964

8:00 a.m.	Section on General Practice Fireside Conference. (Two speakers on general medicine).
9:30 to 11:30 a.m.	Instructional courses.
Morning	2 hours of continuous movies
Afternoon	General scientific program. (Speakers appearing on the section programs Tuesday afternoon are to be invited to fill this program.)
Afternoon	2 hours of continuous movies
Evening	Entertainment

Thursday, October 15, 1964

Morning	To be devoted to a political-social-economic program
Noon	President's luncheon
Afternoon	Final meeting of House of Delegates

Dr. Fisch requested approval of the Council in financing the speakers for the section meetings and suggested an honorarium of $100.00 per day

plus traveling expenses, inasmuch as the section meetings are to be held on Tuesday and the scientific program in which section speakers are to be invited to participate will be held on Wednesday, Dr. Fisch said some of the speakers would have to be paid two days' honorarium plus traveling expenses.

On motion of Drs. Edwards and Donato, the program as outlined was accepted and the Council approved payment of $100.00 per day, plus traveling expenses, to speakers appearing on the section and general scientific programs.

Section officers will be asked to submit their programs by April 1, after which the general scientific program will be compiled.

The entire scientific program will be completed by June 1.

3. *Liaison Committee with Blue Shield.* Dr. Steen, chairman, read a letter from Dr. Glen V. Ryan, president of Mutual Medical Insurance, dated December 19, 1963, concerning the election of a member on the Board of Directors of Blue Shield to fill the vacancy created by the death of Dr. Walter L. Portteus.

The Executive Committee of Blue Shield offered the following suggestion to the Council of the Indiana State Medical Association through the Liaison Committee with Blue Shield regarding future nominations of directors-at-large, in order to best meet the needs of Blue Shield:

> "Permit the two liaison committees to jointly suggest nominees for directors-at-large to the Council. Thereafter if the suggested persons are not satisfactory to the Council, permit the liaison committee to suggest further names until the persons named are satisfactory to all concerned. The Liaison Committee, as now constituted, has the interest of Blue Shield at heart, and the needs of Blue Shield could be taken care of in this manner."

On motion of Dr. Donato, duly seconded, Dr. Lowell I. Thomas, Indianapolis (orthopedics), was nominated to fill the unexpired term of Dr. W. L. Portteus on the Blue Shield Board of Directors. This term will end March, 1966.

Reports of Guests

DR. JOHN D. VAN NUYS; dean, I. U. School of Medicine, reported on:

(1) *Accreditation examination of the medical school,* December 9 through 12, conducted jointly by the Association of American Medical Colleges and the Council on Medical Education of the American Medical Association. "This is the first examination since 1954, and we were accredited without question. We have another nine years in which to function, apparently, without re-examination. The report was very favorable; there were suggestions and recommendations which are under advisement now with the administration of the University."

(2) *Survey on future needs of medical education in the State of Indiana.* The resolution passed by the House of Delegates at the October, 1963, meeting directed the Governor to appoint a study committee to make this survey. The Governor referred this matter to the university because the office of the Govenor had no machinery in which to set up such a survey. The university will propose to the university board of trustees that a consulting firm be employed to conduct this survey. "The survey will take about four months and it will involve not only very close contact with the school of medicine because of records, number of applicants, number of admissions, and all of the details of our operation, but it will also involve the records of the Indiana State Medical Association, the distribution of physicians, the wishes of business, and many chambers of commerce. We have had a number of delegations in from numerous cities in Indiana—Fort Wayne, Muncie, Terre Haute, Evansville, South Bend, Gary, to name some, interested in establishing a medical school in their local communities This firm will be in a position to interview everyone who has expressed an interest. I am convinced at this point that this is timely, in view of the overwhelming number of applicants we have had this year."

(3) *University teaching hospital.* Dr. VanNuys said he believed they would be able to go out on bids for the first unit of the university teaching hospital this spring and have it under contract well before the definite date of June 30 of this year. The first unit will increase the bed capacity by 350 over the present facility. "This will be at the total sum of $13,700,000.00 and will give us a good step forward in developing the physical teaching plan for this very large number of students."

(4) Dr. VanNuys discussed the fact that Indiana communities are not attracting medical graduates. "This is one of the questions to be considered in this survey: Is there any relationship between the number of persons we graduate from the school of medicine who are residents of this state, and the number of physicians who actually start practicing in this state? This is a matter, I think, of great concern to our organization here and to our university, because we are not keeping enough of our own graduates at the moment in Indiana, and we could grind out a lot of doctors and keep on supplying Arizona, New Mexico, and California in a very large way. I honestly can't tell you why some of our Indiana communities are not attractive to our graduates."

(5) Dr. VanNuys spoke again on the shortage of applicants from the rural communities, chiefly because the smaller high schools are not equipped to offer the essential courses for medical work, and students from these smaller schools are not stimulated early enough for medical careers.

Dr. Rifner offered the suggestion that the Commission on Medical Education and Licensure might be requested to look into this situation and to urge each county medical society to encourage and to interest students in the rural areas in medical

practice. "If we had some program where each county medical society went into the local high schools and encouraged the entrance into medical school, this would be a help. Perhaps our commission could work along this line."

On motion of Drs. Rifner and Paris, the Council voted to instruct the Commission on Medical Education and Licensure to develop a program for high schools to encourage students to enter medical school.

Dr. VanNuys mentioned the Explorer Scout program as a good means of orienting students in the smaller areas in the requirements for studying medicine. "We've just got to reach them and we're just not reaching them right now. I don't believe we can do it completely through the machinery of the medical school. I think it has to be an organization sponsored by the state medical association."

State Board of Health Matters

DR. A. C. OFFUTT, State Health Commissioner, spoke on:

(1) *World Health Organization meeting*, which he will attend in March in Switzerland, and at which he will have the following assignments:

a. Problem of world-wide malaria control.
b. Membership on the program and budget committee.
c. Report on accomplishments of the past year in World Health Organization.
d. International problems on community water supplies.

(2) *New licensure program for health facilities* which went into effect January 1, which, Dr. Offutt said, will create some problems as there are still a number of patients being sent to so-called "boarding homes" which have not been licensed and which do not provide any kind of medical care.

(3) *Tuberculosis eradication program.* DR. ROBERT YOHO, of the State Board of Health, reported on the work of the Indiana Coordinating Committee for the eradification of tuberculosis, which was created about three years ago. This committee was composed of representatives of the State Board of Health, the State Tuberculosis Association, and the Indiana State Medical Association and was charged with the task of recommending a more effective program to fight tuberculosis. The report of the coordinating committee has been completed and has been accepted unanimously by all members of the coordinating group. Dr. Yoho said, "The report is intended to indicate concepts of tuberculosis control on which the medical profession, the State Board of Health, and the Tuberculosis Association can agree. It is not an order to put a program into effect. It is merely an outline of what a program might be in the various communities in the state, and if everyone feels that the suggestions made are satisfactory we would hope that later on each of the groups will take the responsibility for implementing the recommendations within their own groups."

Dr. Yoho also said if the Council accepted the report there will be a continuing steering committee, made up of the original Executive Committee and a medical writing committee, to make suggestions as to how the report might be implemented.

Dr. Offutt made two requests of the Council.

(a) That the report be approved as presented, and that the Indiana State Medical Association implement this part in the program, if they approve it, and

(b) That the Council approve the formation of the steering committee to continue in the re-evaluation of the program, thereby insuring the implementation of the program to all various agencies that are involved.

Dr. Offutt also stated that the Indiana Tuberculosis Association, at their annual meeting in April, would like to start their part of the program at that time and therefore the Tuberculosis Association would like to know where the state medical association stands before it goes ahead.

The members of the Council had not received copies of the coordinating committee's report. Therefore action of the Council on the report was deferred until April 1 and the councilors were instructed to write their approval or disapproval of the plan to the chairman of the Council.

(4) *Health Facilities Program.* Several discussed this subject, it being pointed out that it is a grant operation in which the Indiana Hospital Association is evaluating the entire program of hospital operation in Indiana.

On motion of Dr. Edwards, seconded by many, the following resolution was adopted by the Council:

RESOLUTION:

Whereas, the proper planning for medical facilities assures a community of adequate services without excessive or unnecessary capital or operational costs which result in increased charges to the patient; and

Whereas, the Indiana State Medical Association has always endorsed highest quality medical care at reasonable cost; and

Whereas, the Indiana State Board of Health, with the assistance of the Advisory Hospital and Health Center Planning Council, the Hospital Licensing Council, and the Health Facilities Licensing Council, is legally responsible for planning the orderly development of health facilities, administration of Hill-Burton funds, and the licensing of health and hospital facilities; therefore be it

Resolved that the Council of the Indiana State Medical Association recommends to the State Board of Health and its related councils that its planning activities be extended and strengthened, and pledges its support to the State Board of Health in its efforts to secure an adequate budget to conduct its planning functions in this area; and be it further

Resolved that since the structure through which effective planning for the development of adequate health facilities now exists, the strengthening of this structure should receive the undivided attention of the Indiana State Medical Association.

(5) *Silver nitrate in the eyes of the newborn.* **On motion duly made and seconded, the Council went on record as sustaining the action of the State Board of Health in disapproving the use of a sulfa preparation instead of silver nitrate in the eyes of the newborn.**

(6) *Negligence of county health officer.* **The failure of county health officer to submit the proper reports to the State Board of Health was referred by the Council by consent to the Grievance Committee with the request that the Grievance Committee expedite action in this matter.**

Economic and Organization Matters

1. 1963 *Membership report by districts,* as follows, was presented:

MEMBERSHIP REPORT
INDIANA STATE MEDICAL ASSOCIATION

December 31, 1963

DISTRICT	Members ISMA	# Delegates 1964 Session	AMA	Gain or Loss Over 1962 ISMA	Gain or Loss Over 1962 AMA	Removed from ISMA Non-Payment	Deaths	Non-Members Elig.	Non-Members Non-Elig.
1st District									
Gibson	16	1	16	+1	+2				
Perry	12	1	12	—1	—1		1		
Pike	4	1	4						
Posey	10	1	10						
Spencer	5	1	4	—1			1	1	
Vanderburgh	239	5	235	+4	+5		3	9	
Warrick	9	1	10	—2	—1			1	
Total	295	11	291	+1	+5		5	11	
2nd District									
Daviess-Martin	20	2	19	+1	+1	1	1	1	
Greene	16	1	9						
Knox	41	1	39						
Owen-Monroe	62	2	57	+4	+4	1		2	
Sullivan	15	1	13				1		
Total	154	7	137	+5	+5	2	2	3	
3rd District									
Clark	38	1	37					2	
Dubois	23	1	18	—1	—2			2	
Floyd	38	1	37	—2	—3		2	1	
Harrison-Crawford	11	2	11	—2	—2				
Lawrence	24	1	22	—1	—1				
Orange	9	1	9						
Scott	4	1	3	+1				3	
Washington	8	1	8						
Total	155	9	145	—5	—8		2	8	

DISTRICT	Members ISMA	# Delegates 1964 Session	AMA	Gain or Loss Over 1962 ISMA	AMA	Removed from ISMA Non-Payment	Deaths	Non-Members Elig.	Non-Elig.
4th District									
Bartholomew-Brown	43	2	42	+2	+2		3	1	
Dearborn-Ohio	22	2	21		+1		1	1	
Decatur	12	1	10		+1				
Jackson-Jennings	25	2	22	+1	+1		1	3	
Jefferson-Switzerland	25	2	23	—1	—2			1	
Ripley	11	1	9	+2	+2			1	
Total	138	10	127	+4	+5		5	7	
5th District									
Clay	13	1	13				1		
Parke-Vermillion	26	2	26	+2	+2			1	
Putnam	16	1	16	—1	—1	1	1	2	
Vigo	118	2	117	—1	—1			1	
Total	173	6	172			1	2	4	
6th District									
Fayette-Franklin	18	2	18						
Hancock	20	1	20	—1	—1				
Henry	42	1	42	—2	—2		3	1	
Rush	15	1	15					1	
Shelby	19	1	19	+1	+1		1	4	
Wayne-Union	71	2	66	—2	—2	1	1	1	
Total	185	8	180	—4	—4	1	5	7	
7th District									
Hendricks	22	1	22	+2	+2			1	1
Johnson	32	1	32	+2	+2		1		
Marion	1067	21	1065	+20	+21	2	15	47	2
Morgan	17	1	17	+2	+3		2	3	
Total	1138	24	1136	+26	+28	2	18	51	3
8th District									
Delaware-Blackford	115	3	110	+2	+4	2	4	3	1
Jay	17	1	15	—2	—2		1		
Madison	100	2	96	—4	—4		3	6	1
Randolph	22	1	19		+2	1			
Total	254	7	240	—4		3	8	9	2
9th District									
Benton	9	1	8						
Boone	18	1	18					2	
Clinton	20	1	20	+1	+1				
Fountain-Warren	15	2	15	—1	—1				
Hamilton	26	1	20	+1	+1	1		1	

DISTRICT	Members ISMA	# Delegates 1964 Session	AMA	Gain or Loss Over 1962 ISMA	Gain or Loss Over 1962 AMA	Removed from ISMA Non-Payment	Deaths	Non-Members Elig.	Non-Members Non-Elig.
9th District (Cont.)									
Montgomery	27	1	27	+1	+1		2	3	
Tippecanoe	114	2	114	—3	—2	5	2	1	
Tipton	11	1	11						
White	11	1	11	—1	—1				1
Total	251	11	244	—2	—1	6	4	7	1
10th District									
Jasper	8	1	8				1		
Lake	426	9	400	—6	+2	9	7	12	2
Newton	4	1	4						
Porter	33	1	33	+4	+4		1	2	
Total	471	12	445	—2	+6	9	9	14	2
11th District									
Carroll	9	1	9						
Cass	39	1	37	—1	—1		2	1	2
Grant	68	1	68	+1	+2			5	
Howard	64	1	64	+5	+5			1	1
Huntington	23	1	22	—1	—1			1	
Miami	13	1	12	—1	—1			6	1
Wabash	25	1	24	—1	—1		1	1	1
Total	241	7	236	+2	+3		3	15	5
12th District									
Adams	13	1	13	—1	—1	1		1	
Allen	281	6	278	+6	+4		1	6	2
DeKalb	20	1	20	+1	+1			1	
LaGrange	10	1	10				1		
Noble	16	1	16					2	
Steuben	13	1	13	—1	—1			2	
Wells	33	1	34	—2	—2	1		2	
Whitley	19	1	19	—2	—2	1			
Total	405	13	403	+1	—1	3	2	14	2
13th District									
Elkhart	109	2	107		+1	1	1	5	
Fulton	11	1	11					1	
Kosciusko	17	1	16	—1	—1			2	
LaPorte	98	2	96	+4	+4			1	
Marshall	26	1	25				1		
Pulaski	6	1	5		—1				
St. Joseph	237	5	237	+2	+2		4	8	1
Starke	6	1	6						
Total	510	14	503	+5	+5	1	6	17	1

DISTRICT	Members ISMA	# Delegates 1964 Session	AMA	Gain or Loss Over 1962 ISMA	AMA	Removed from ISMA Non-Payment	Deaths	Non-Members Elig.	Non-Elig.
				SUMMARY					
1st District	295	11	291	+1	+5		5	11	
2nd District	154	7	137	+5	+5	2	2	3	
3rd District	155	9	145	—5	—8		2	8	
4th District	138	10	127	+4	+5		5	7	
5th District	173	6	173	+1	+1	1	2	4	
6th District	185	8	181	—4	—3	1	5	7	
7th District	1138	24	1136	+26	+28	2	18	51	3
8th District	254	7	240	—4		3	8	9	2
9th District	251	11	244	—2	—1	6	4	7	1
10th District	471	12	446		+7	9	9	14	2
11th District	241	7	236	+2	+3		3	15	5
12th District	405	13	403	+1	—1	3	2	14	2
13th District	510	14	503	+5	+5	1	6	17	1
Total	4371*	139	4262	+31	+46	28	71	167	16

* includes 3 honorary members and 39 full dues paying members who are out of the state.

2. *Remission of state dues.* The Council voted the remission of state dues as follows:

Marion County—Three members, two because of illness and retirement from practice, and one because of retirement, **on motion of Dr. Donato, taken by consent.**

Putnam County—One member, retired from active practice, **on motion of Dr. Wiseman, taken by consent.**

3. *Nomination of Blue Shield Board members-at-large.*

On motion of Dr. Black, duly seconded, Dr. John W. Beeler, Indianapolis, (radiology), was nominated to succeed himself, and on motion of Drs. Edwards and Bennett, Dr. William E. Bayley, Lafayette (pathology), was nominated to succeed himself. These nominations are for the three-year term ending March, 1967.

On motion of Dr. Donato, duly seconded, Dr. Lowell I. Thomas, Indianapolis (orthopedics), was nominated to fill the unexpired term of Dr. Walter L. Portteus, deceased. Dr. Thomas' term will end in March, 1966.

4. *District nominations for Blue Shield Board members for three-year terms ending March,* 1967, *were confirmed as follows:*

Joe M. Black, M.D., Seymour
General Practice — District 4

Glen V. Ryan, M.D., Indianapolis
General Practice — District 7

Milton B. Gevirtz, M.D., Hammond
General Practice and Surgery — District 10

Edward G. Dovey, M.D., Elkhart
Urology — District 13

5. DR. DENNIS S. MEGENHARDT, member of the Professional Advisory Committee of Blue Cross, reported that the Blue Cross Board members were pleased with the liaison they had had with the Council and the association officers during the past year. The attendance was exceptionally good,—at least 80%.

New Business

I. U. Alumni Day. Dr. Shields announced that Dr. Edward R. Annis had been invited to be the principal speaker at the I. U. alumni meeting on May 20 and asked that the councilors take this word back to their districts and invite everybody, whether I. U. alumni or not, to attend this meeting.

The chairman of the Council asked that district societies try to change their district meeting dates if these meetings will conflict with the alumni meeting on May 20, 1964.

Date for Spring Meeting

The date of April 26, 1964, was selected for the next meeting of the Council.

There being no further business, the meeting was adjourned. ◄

COMMERCIAL ANNOUNCEMENTS

MUNCIE, Indiana: Fully equipped eight room air conditioned office available immediately. Sale or lease. Excellent location occupied by G.P. for past 11 years. Contact Walter Hollowell, 2307 S. Madison, Muncie.

ASSOCIATE desired for two man general practice in small Indiana town 15 miles from South Bend. Inspection of our modern facility and personal discussion of this opportunity invited. Reply to Box No. 306, The Journal, ISMA, 3935 North Meridian St., Indianapolis, Ind.

OUTSTANDING opportunity for physician specializing in internal medicine to be affiliated with well established group in large metropolitan center. Five internists practicing in group. Compensation excellent and no investment necessary. Reply to Box 310, The Journal, ISMA, 3935 N. Meridian St., Indianapolis.

G.P. WANTED to join fast growing general practice, complete modern facilities and hospital privileges; salary open, leading to partnership. Town of 8,000, drawing population 17,000 Anesthesiology and surgery interests preferred. Write Box No. 311, The Journal, ISMA, 3935 N. Meridian St., Indianapolis.

FOR SALE: Picker Century x-ray-fluroscope, 100 Ma—100 Kv., excellent condition and all accessories also Bucky tilt table. Asking $1000.00 or offer. Contact Michael Truman, M.D., 1070 Millville Avenue, Hamilton, Ohio.

FOR RENT: Bungalow office to share with dentist in S.E. Fort Wayne residential area. Four rooms designed for physician; office area and reception room. Available March, 1964. Call 744-3411.

SORRY, psychiatric residencies filled. We cannot accept additional applications for processing for July, 1964. Applications are welcomed for July, 1965. Fully approved program of balanced didactic and clinical training. Five year career plan. For full details write Dr. Curtis W. Page. Director of Training. Traverse City State Hospital, Traverse City, Mich.

PART-TIME physician required for medical department of Gary Sheet and Tin Mill. Contact Thomas Speer, M.D., Tel. 883-0298.

WANTED: Staff physician for Parramore Hospital (County TB) 144 beds. Indiana license required. Apply, P. H. Becker, M.D., Adm., Parramore Hospital, Crown Point, Ind.

WANTED: General physicians in fully accredited 1300 bed dynamically oriented psychiatric hospital. Salary from $11,900. Citizenship and Indiana license required, minimum requirement one year internship. Excellent opportunity for developing in psychiatry, neurology or general medicine. Complete maintenance available, small deduction. Apply to Ott B. McAtee, M.D., Superintendent, Madison State Hospital, Madison, Ind.

WANTED early June, Christian doctor to care for practice for six weeks while on vacation. Live in doctor's home. Air conditioned office. Must hold Indiana license. Contact C. L. Entner, M.D., Washington and Meridian Sts., Dunkirk, Ind.

SPECIAL NOTICE

June issues and the 1963-64 Roster may be obtained from the JOURNAL, 3935 N. Meridian, Indianapolis.

Roster: $3.00 each.

Yearbook: $5.00 each.

NOTICE

Commercial announcements are carried in the Journal as a special service to ISMA members. Only advertisements considered to be of advantage to members by the Journal editorial board will be accepted. Those of a truly commercial nature (i.e., firms selling brand products, services, etc.) will be considered for display type advertising.

Charges for commercial announcements are:

First four lines: $3.00
each additional line: 50¢

ISMA members may repeat an ad in the following issue without charge. This is limited to one free ad per year.

Advertiser will be billed at the end of the designated period of insertion(s), or at the end of each three-month period, whichever is shorter.

DEADLINE: Fifth day of month PRECEDING month of issue. (The Journal is in press approximately one month.)

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This is Volume I of a new monograph series, "Major Problems in Clinical Pediatrics." Each volume will take a significant problem facing pediatricians today and exhaustively delineate current knowledge about the disorder and how it may best be managed. Other volumes scheduled in addition to the one below will cover Jaundice, Severe Infections, and Hypoglycemias. Consulting Editor of the Series—Alexander J. Schaffer, M.D.

The Lung and its Disorders in Newborn Infants exemplifies the entire series. Dr. Avery first draws a superb picture of the significant anatomic and physiologic aspects of fetal and neonatal respiration. She follows this with clinical, up-to-the-minute assessment of respiratory distress—in disorders ranging from *choanal atresia* to *pulmonary hemorrhage.* You'll find a wealth of practical, well-illustrated advice on *management of hyaline membrane disease, on differential diagnosis of the various respiratory abnormalities, on resuscitation of the asphyxiated newborn, on data showing normal lung volumes in infants, and on recognition of both normal and abnormal chest films.* Here is a complete, definitive picture in one single source.

By MARY ELLEN AVERY, A.B., M.D., Assistant Professor of Pediatrics, Johns Hopkins School of Medicine; Pediatrician-in-charge, Newborn Nurseries, Johns Hopkins Hospital. About 225 pages, 6⅛" x 9¼", illustrated. About $7.50.

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NEW! Stoddard — Case Studies in Obstetrics and Gynecology

Here is a stimulating new book based on the case-study method of instruction. It will aid you greatly in management of virtually all the important problems encountered in the practice of obstetrics and gynecology. 60 problems are discussed, ranging from *premenstrual tension* to *Rh isoimmunization.* Dr. Stoddard begins each discussion with a typical case history, describing symptoms and signs, results of the physical examination and laboratory tests, type of treatment offered, and long-term results. Next you'll find a thoughtful discussion in which that particular type of disorder is described as to incidence, pathology, prognosis, etc. Then follows a series of provocative questions (the type a consultant would be asked) with sensible answers on pathology, type of treatment prescribed, alternative methods of treatment, effectiveness of therapy, etc. You'll welcome the advice set forth on such vital disorders as: *early abortion; cancer and pregnancy; dysmenorrhea; adrenal virilism; carcinoma in situ of the cervix; toxemia of pregnancy; obstetrical anesthesia accident; etc.* This valuable new book will help you screen important from unimportant aspects of a case, help you avoid a stereotyped approach to management, give you details of unusual cases you may not yet have encountered.

By F. Jackson Stoddard, M.D., Associate Clinical Professor of Obstetrics and Gynecology, Marquette University School of Medicine, Milwaukee, Wisconsin. 312 pages, 6⅛" x 9¼", illustrated. About $10.00.

New—Just Ready!

SJG4-64

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Please send and bill me:

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☐ Cecil-Conn—*Specialties*. . About $19.00
☐ Easy Pay Plan ($5 per month)
☐ Stoddard—*Case Studies in Obstetrics & Gynecology*. . About $10.00

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April 1964

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Office of Publication

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All articles must be typewritten, double-spaced with margins of one inch.

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Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members. Cost of color illustrations must be shared by the author.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible. However, the right is reserved to reduce in length or reject any article.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication in THE JOURNAL of the Indiana State Medical Association.

Communications dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 1802 North Illinois Street, Indianapolis 2, Indiana. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 3935 N. Meridian, Indianapolis 8.

Advertising rates will be furnished on request. Copy must be received by the 5th of the month preceding month of issue. (Scientific manuscripts must be received at least two weeks earlier if geared for a specific issue.)

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About Our Cover on page 308.



when lowered skin temperature suggests

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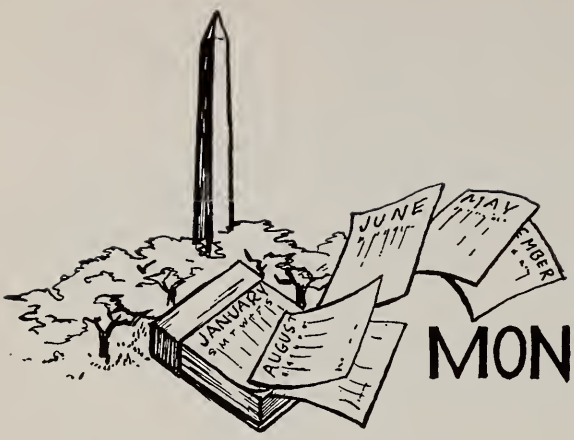
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Symbol of service in medicine



This summary of what is happening in Washington is prepared by A.M.A.'s Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

MONTH IN WASHINGTON

WASHINGTON D.C.—The federal government is requiring assurances from sponsors of pending future Hill-Burton hospital projects that there will be no racial discrimination as to either patients or physicians.

Anthony J. Celebrezze, secretary of Health, Education and Welfare, disclosed the new policy in testimony before the House Commerce Committee during testimony on legislation that would enlarge the Hill-Burton program and extend it for five more years.

His testimony came a week after a Supreme Court decision that let stand an anti-segregation order against two Greensboro, N. C., hospitals.

Following the action by the Supreme Court, Celebrezze said, "I directed that the following additional steps be taken:

"(1) That we make permanent the earlier decision to approve no new applications under the "separate but equal" provision of the (Hill-Burton) law;

"(2) That we require a non-discrimination assurance in admittance from those pending projects previously approved on a "separate but equal" basis;

"(3) That we seek from all pending projects an assurance that there will be no discrimination on the basis of race, creed, or color in granting staff privileges; and

"(4) That the application forms to be used hereafter be amended to require of all applicants whose application has not been finally approved, a non-discrimination assurance covering staff privileges and admissions, and that all portions and services of the facilities be made available without discrimination on account of race, creed or color."

Celebrezze also said that consideration was being given to calling a meeting of the leaders in organized medicine, in the hospital and related health fields, with a view toward implementing non-discrimination programs voluntarily. "I would hope that such a voluntary program would encompass not only Hill-Burton hospital facilities but all hospitals in the United States," he said.

The Supreme Court's "let stand" ruling foreshadowed a hospital desegregation drive throughout the south.

A spokesman for the National Association for the Advancement of Colored People said hospital desegregation law suits were planned for a number of

other southern cities. A spring trial already has been scheduled on a complaint against Grady Memorial Hospital in Atlanta, the largest public hospital there. Another suit involved a hospital in Newport News, Va.

The Supreme Court let stand a decision handed down Nov. 1, 1963, by the Fourth U. S. Circuit Court of Appeals which held that hospitals built with Hill-Burton funds could not practice racial segregation as to both doctors and patients despite the "separate but equal" provision in the Hill-Burton act of 1946.

The Supreme Court issued only a brief order, with no explanatory opinion.

Eleven negro doctors, dentists and patients brought suit against the Wesley Long Community and Moses H. Cone Memorial hospitals in Greensboro federal district court in 1962. The negro litigants petitioned for an anti-segregation order and for elimination of the "separate but equal" provision in the law.

The issue was whether participation by the State or Federal government, or both, brings government into the picture sufficiently to invoke the protection to individuals guaranteed in the U.S. Constitution. The guarantee of "equal protection of the laws" laid down in the 14th amendment, and other constitutional rights, may be enforced only against governments, not against private individuals.

The district court at Greensboro dismissed the suit of the negroes but it was overruled by the circuit court of appeals which held that the degree of state and federal involvement is sufficient under the Hill-Burton Program to bring the hospitals within the framework of constitutional requirements. This opinion noted that the United States had appropriated more than $1.2 million to Cone Memorial and almost $2 million to Wesley Long.

"The massive use of public funds and extensive state-federal sharing in the common plan are all relevant factors," the circuit court said.

At the time the suit was filed, Cone Memorial did not afford Negro doctors and dentists staff privileges and admitted only a few Negro patients. Long Hospital was completely segregated. Both are non-profit charitable corporations under North Carolina law.

Later, Cone Hospital announced it would consider staff applications from Negroes.

FEDERAL AID TO NURSING EDUCATION

President Johnson asked Congress to approve a program of federal aid to nursing education with a goal of increasing the nation's supply of professional nurses to 680,000 by 1970, an increase of 130,000.

In a special health message to Congress, Johnson also requested an extension of the Hill-Burton hospital construction program and again called for legislation that would increase social security taxes to provide hospitalization and other limited health care for the aged.

Dr. Edward R. Annis, president of the American Medical Association, termed the "fedicare" section of the president's health message as "a remarkable document of inconsistency and misinformation on health care for the elderly."

"Mr. Johnson declares that elderly Americans should not be subjected to a test of need for tax-paid medical care, but at the same time he urges

Continued on page 308


RECOGNIZE
THIS PATIENT?
"I don't sleep well . . . I dream a lot . . . wake up tired and irritable. I don't have any appetite . . . I'll never be cured."

When you recognize signs of depression and anxiety and associate them with an organic condition—add 'Deprol' to your therapy.

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When you recognize depression and anxiety traceable to an emotionally charged situation with no somatic disorder—start the patient on 'Deprol'.

Typical situations in which 'Deprol' is indicated:

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meprobamate 400 mg. + benactyzine hydrochloride 1 mg.

BRIEF SUMMARY: *Indications:* Depression, especially when accompanied by anxiety, tension, agitation, rumination or insomnia. *Side Effects:* Slight drowsiness and, rarely, allergic reactions, due to meprobamate, and occasional dizziness or feeling of depersonalization in higher dosage, due to benactyzine, may occur. Meprobamate may increase effects of excessive alcohol. Use with care in patients with suicidal tendencies. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. Withdraw gradually after prolonged use at high dosage. *Complete product information available in the product package, or to physicians upon request.*

USUAL ADULT DOSAGE: 1 tablet q.i.d. May be increased gradually, as needed, to 3 tablets q.i.d.; with establishment of relief, may be reduced gradually to maintenance levels.

SUPPLIED: Light-pink, scored tablets. Bottles of 50.

WALLACE LABORATORIES / *Cranbury, N. J.*

CD-817

Continued from page 305

all states to enact adequate Kerr-Mills medical aid for the aged programs," Dr. Annis said. "Eligibility for Kerr-Mills benefits is based on need . . .

"Mr. Johnson claims that the average worker would pay no more than a dollar a month to pay for this program of hospitalization for the elderly. But the average industrial wage in this country is more than $100 a week, and the tax increase proposed by Mr. Johnson would cost the $100 a week worker $27.50, not $12. Employers would pay an additional $27.50 for a total payroll tax increase of $55 on every $100 in wages. And that would be only the beginning.

"Why should everyone over 65 get hospitalization at the expense of wage earners just because a few need help? Why should the workers of America be forced to pay higher taxes for hospitalization for everyone over 65, many of whom are wealthy and millions of whom have health insurance, just because they've had a birthday?"

The AMA vigorously opposes the Administration's program that would be financed through social security, but supports the Kerr-Mills program which was enacted into law in 1960. ◄

About Our Cover

The figures on our cover are those reported for the election year of 1960. In the primary election the percentage of registered voters who actually cast their ballot was only 40.19%!

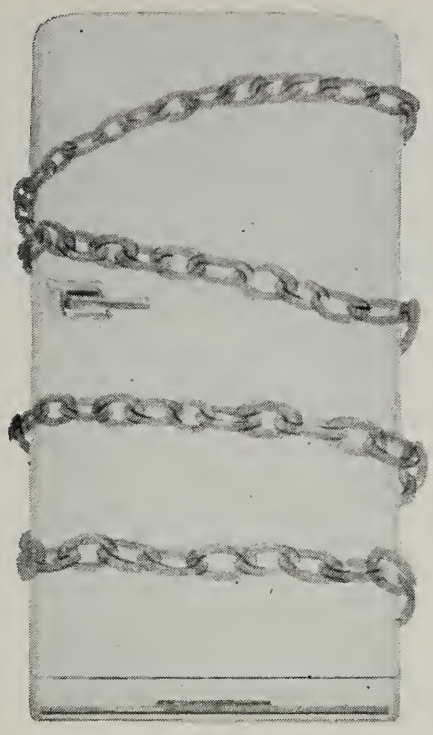
In the general election the following November, the percentage was higher, but not high enough, just 81.95%.

It seems ironic that a nation holding the enviable privilege of expressing its choice of leadership without threats, coercion or fear of reprisal does not exercise that privilege to the full.

In 1830, 134 years ago, Daniel Webster said ". . . The people's government, made for the people, made by the people, and answerable to the people." We are *still* those people, we must not sit back and let the other fellow do it all. Each and every one of us must register and we must vote.

Urge your neighbors, your friends and your patients to play their part in the affairs of our country.

The aim for the 1964 elections must be a 100% turnout at the polls, you can do a lot to ensure this.—M.E.R.



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is an easier way to help control food craving & keep the reducer happy

With "hunger pains" abolished, the patient can shrug off the chains of psychogenic craving that bind him to his habit of overeating and cooperate cheerfully with the prescribed diet.

In obesity, "...our drug of choice has been methedrine (methamphetamine hydrochloride)...because it produces the same central effect with about one-half the dose required with plain amphetamine, because the effect is more prolonged, and because undesirable peripheral effects are significantly minimized or entirely absent." Douglas, H. S.: West. J. Surg. **59**:238 (May) 1951.

Description: Each scored tablet contains 5 mg. 'Methedrine' brand Methamphetamine Hydrochloride.

Dosage: 2.5 mg. (½ tablet) 3 times daily. May be increased gradually according to response; more than 10 mg. daily rarely is needed. The last dose of the day should not be taken later than 6 hours before bedtime.

Side effects: Insomnia may occur if taken later than 6 hours before retiring. The usual peripheral actions of sympathomimetic amines (vasoconstriction and acceleration of the heart) are minimal and little noticed on low or moderate dosage.

Contraindications and precautions: Should not be used in patients with myocardial degeneration, coronary disease, marked hypertension, hyperthyroidism, insomnia or a sensitivity to ephedrine-like drugs. Moderate hypertension in the obese is not necessarily a contraindication since it may be relieved as the overweight is reduced.

Supplied: Tablets 5 mg., scored, in bottles of 100 and 1000.

Complete literature available on request from Professional Services Dept. PML.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

From the Journal 50 Years Ago

*"Get it Straight"**

Please get it straight in your noodlums that some of you still owe me old bills, and that all humans need money, and that a doctor is just human, whether you think so or not. Some people seem to think he is one-half owl and the other half jackass; the owl proclivities making him prefer to be up at night instead of sleeping, and the jack stock he is supposed to possess enabling him to endure all kinds of hardships and live on half feed and hot air promises.

Some people prefer, it seems, to call a doctor at night, when, if they had to go after him, they would not walk a hundred yards for him. It's awfully easy to ooze up to the wall and call a doctor over the phone, then jump back in bed and wait for him to come through the darkness and cold, and then expect him to come in looking pleasant. I want to tell you it's about as easy to practice medicine and always be pleasant as it is to sit long in a Texas red ant bed and look unconcerned.

* * *

Another thing—get it straight—I charge extra for night work, you bet your sox, and I charge extra for work in unusually bad weather in daytime. Night means, when the sun is blinkin'.

The cost of living and prices in every line of business have advanced during recent years anywhere from one-fourth to double or more, all except the country doctor's fees. Beginning the first of 1914 I shall charge for day calls in town $2.50 per call, and $1.00 extra, or $3.50, for night calls. If I make two or three or a dozen calls on the same day, I make no reduction on charges. It's as much trouble to make one call as another, and if you don't want to pay extra trips don't belly-ache for me to make them. Grant knows that if you leave it to me I will make as few as possible. Another thing, please get it straight, I charge for prescribing over the phone. Calls to the country are $1.00 per mile, one way, except at night, when an extra charge will be made depending on the distance, weather, etc.

Now, be sure you get this straight; cut it out and paste it in your hat; when you ask me to "fix up" some medicine for yourself or folks, don't ask me what the medicine is worth and think when you pay for the medicine that you've paid all. I charge for my services and charge from $1.00 up. I am not SELLING medicine, I am PRESCRIBING it, and I'm not dishing it out for nothing. I had very good health before I came here. Moreover, cheap doctors are, as a rule, like all other cheap commodities, not worth a darn.

I charge, and always have, $15 for confinement cases in town and a short distance from town, and after that, mileage is added. Extra charges are made for extra time of detention or when forceps are used. Naturally, a doctor expects cash for these cases, for you have nine months' warning in which to dig up the dough.

Now listen, I don't care enough about the practice of medicine to practice just for a job; I want pay for it, and unless you pay, why, I simply don't want your business; and that's not all, you need not send for me if you think I am going to carry your account and troubles indefinitely.

Dr. Ballard."

*Through the courtesy of Dr. Herbert F. Williams, *The Journal* is enabled to reprint the above bona fide advertisement from the *McLean* (Texas) *News*. *JISMA*, April, 1914.

In allergy, this antihistamine works with no more sedation than placebo*

The therapeutic response to Dimetane (brompheniramine maleate) is eloquent proof that a *potent* antihistamine does not have to be a sedative, too. You may expect unsurpassed relief of symptoms promptly in most types of allergy because Dimetane (brompheniramine maleate) *works* with a very low incidence of side effects. Indeed, as shown in a double-blind crossover study, with no greater incidence of sedation than placebo.*

*Schiller, I. W. and Lowell, F. C.: New England J. Med. *261*:478, 1959.

CONTINUOUS ACTION UP TO 10-12 HOURS

Dimetane® Extentabs®

(brompheniramine maleate, 8mg.&12mg.)

BRIEF SUMMARY: Indications: Dimetane (brompheniramine maleate) is a potent antihistamine effective in a wide variety of allergic states.

Side Effects: Hypersensitivity reactions, including skin rashes, urticaria, hypotension, and thrombocytopenia, have been reported rarely. Occasional transitory drowsiness, lassitude, nausea, or giddiness may be encountered. Dryness of the mouth and mydriasis have been reported infrequently.

Precautions: Until response is determined, patient should be cautioned against engaging in mechanical operations requiring alertness.

Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.

ALSO AVAILABLE: New lower strength Dimetane *8 mg.* Extentabs (brompheniramine maleate 8 mg.); conventional tablets (4 mg.); Elixir (2 mg./5 cc.); Injectable (10 mg./cc. ampuls, and 100 mg./cc. in 2 cc. vials).

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PHARMACEUTICAL RESEARCH



LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Eureka, Ponce De Leon!

Research conducted by Dr. Joseph C. Muhler [a dentist] of Indiana University opens up the possibility of something being added to food—a breakfast cereal perhaps—to halt a process of aging.

So far, the food additive appears to prevent brittleness of bones, one of the items on the debit side of the ledger when a person becomes old in years.

Could the Fountain of Youth be around the corner? Perhaps Ponce de Leon misunderstood the Indians when they told him he would find the fountain on the Island of Bimini. Maybe the Indians were trying to say "Bloomington" instead and the Spanish explorer lacked an interpreter with an ear keen enough to catch the subtle difference in sound.—*Indianapolis Star,* Feb. 27, 1964.

Hospitals Move Together

The private, voluntary hospitals of Indianapolis are meeting a public responsibility to combat rising patient costs by the possible pooling of some of their major facilities.

At the same time that most of these institutions are furthering their individual expansion programs to meet increased treatment demands, they have established a central services corporation. As a matter of first priority, the corporation will consider the feasibility of establishing a common laundry. This, it is estimated, would save the hospitals—and their patients who must pay for these services—$200,000 to $300,000 a year. The non-profit corporation would be able to float bonds or negotiate loans for the unified laundry project.

Eventually, the organization expects to bring into cooperative being other hospital services which now are conducted independently at a far greater cost than pooled facilities. These may include computer and data processing, food, drug and equipment purchasing, building maintenance, an equipment pool, blood bank, record storage and educational programs for nurses and other personnel.

This cooperative cost-cutting must be regarded as a necessary preliminary to the Indianapolis Hospital Development Association's program to organize $65 million in planned hospital expansion into a comprehensive campaign that will almost double the county's facilities by 1973.

Such planning ahead must be regarded as mandatory here. It is estimated that by 1970—only six years from now—metropolitan Indianapolis will have a population of 1,250,000, with a need for almost twice the 3,700 hospital beds now available.

The people of this community should be glad civic-minded citizens are joining hospital officials in their program to help hold down the spiraling costs of operation which, of course, are reflected in patient charges. Cooperative economy is of basic importance to the success of the hospital expansion program, and should be welcomed by everyone.—*Indianapolis News,* Feb. 3, 1964.

Help for Aged

It's been overlooked in the clamor over decisions that activated the reapportionment act and the special prosecutor bill despite Governor Welsh's earlier veto, but another important bill vetoed by the governor also has been declared passed by the

Continued



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Indiana Supreme Court.

This is an Indiana measure that would implement the federal Kerr-Mills Act, which provided for hospital and medical care for the aged through federal grants matching state funds. It was passed a couple of years ago as the answer to the medicare proposals that tie such care to Social Security payments.

The Kerr-Mills Act, however, applies only in states that pass a state act setting up the conditions for such medical and hospital care to be granted. Only New York state, under Governor Rockefeller, is using the federal help provided by the Kerr-Mills Act to any great extent. New York's law has minimum restrictions on who is eligible. Other states have passed laws with extremely rigid qualifications which make such care available only to the greatest hardship cases.

The Indiana enabling act that was vetoed by Governor Welsh because he didn't consider the law went far enough is somewhere in between the most liberal and most rigid interpretations of need.

Governor Welsh claimed the law did nothing that existing state programs don't already accomplish and could run into wasteful duplication.

Now that the Supreme Court has declared this vetoed law stands, however, it is up to the people of Indiana to give it the fair trial it deserves—even though President Johnson is pushing once more the concept of medicare tied to Social Security.—*Hammond Times,* Feb. 18, 1964.

Good Advice—By George

Every now and then we reread the Farewell Address given by George Washington to the Congress and the American people in 1796. We sometimes wonder whether school children or their teachers or politicians and bureaucrats ever do the same.

It might be instructive. For Washington knew as well or perhaps better than any man who helped found and run this country what dangers should be avoided and what positive steps had to be taken to preserve this free society into the future. He knew why the Constitution was written as it was and the separation of powers was devised.

Here is some of his advice. We'll be passing on more every now and then.

"It is important . . . that the habits of thinking in a free country should inspire caution, in those entrusted with its administration, to confine themselves within their respective constitutional spheres, avoiding in the exercise of the powers of one department to encroach upon another.

"The spirit of encroachment tends to consolidate the powers of all departments in one, and thus to create, whatever the form of government, a real despotism

"Of all the dispositions and habits which lead to political prosperity, religion and morality are indispensible supports. In vain would that man claim the tribute of patriotism who should labor to subvert these great pillars of human happiness

"And let us with caution indulge the supposition that morality can be maintained without religion Reason and experience both forbid us to expect that national morality can prevail in the exclusion of religious principle."

There are still a lot of Americans who believe thus. But they don't seem to be running things.—*Indianapolis Star,* March 9, 1964. ◄

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Letters

to the editor

February 22, 1964

To the Editor:

Concerning the guest editorial Fiat Lux (*JISMA,* Feb. 1964, pp. 146-47), I would like to call your attention to an article in *Car and Driver* which is a nationally circulated magazine, ridiculing we gullible Hoosiers for using these little lights.

I'm afraid I have to agree with *Car and Driver.*

Robert C. Colvin, M.D.
107 State St.
Newburgh, Indiana

—Support *The Journal* Advertisers—

March 9, 1964

To the Editor:

This summer, for the 10th season, Riley Memorial Association will sponsor six weeks of camping for crippled boys and girls at Camp Riley in Bradford Woods near Martinsville.

Any physically handicapped boy or girl, ages eight through 15, is eligible to apply and we are most anxious that all parents of crippled children know of the benefits of this program.

Perhaps there is a child in your community who would benefit from this experience—as have hundreds of others who have attended during the past nine years.

The non-profit camps are made possible on a continuing basis by the generous support of many organizations and individuals. A "campership" of $60.00 will provide two weeks at camp for a handicapped child and make possible an experience never to be forgotten. Camperships are awarded on a basis of need.

Cordially yours,
John W. Hillman
Executive Secretary
James Whitcomb Riley
Memorial Association ◄

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The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Supervised by THE COUNCIL

Volume 57 — April 1964 — Number 4

A Rational Approach to Oxygen Therapy

RYLAND ROESCH, M.D.
V. K. STOELTING, M.D.
*Indianapolis**

IF WE EMPLOY an oxygen enriched atmosphere in the treatment of our patients, we should do it with the same regard for effectiveness that we follow when prescribing any therapeutic regimen. Frequently oxygen therapy is utilized though it offers little advantage to the patient. The order "oxygen tent" may be written when one is indecisive about the diagnosis or treatment. In these circumstances oxygen is ordered because it is assumed to be innocuous, and may be helpful.

However, such an order has been known to be followed as written, the patient placed in a carefully sealed tent, but no oxygen administered as none was ordered. Perhaps more disturbing is the fact that often when oxygen is needed, it is given in such an ineffective manner that the patient does not derive the full benefit from it. Therefore a brief review of oxygen transport, indications for oxygen therapy and technics of administration is presented.

Fortunately for us the atmosphere contains ample oxygen to sustain life. Furthermore our oxygen transport system is buffered by considerable reserves and is geared to deliver sufficient oxygen for metabolic requirements should the source of supply be reduced. For example the concentration of oxygen in the air may be lowered by one-half from the normal 20 volumes % to 10 volumes %; yet the hemoglobin will be reduced in saturation from 98% to only 75%. In other words though the oxygen presented to the blood is reduced by one-half, the oxygen content of the blood is reduced by only one-fourth. This phenomenon is made possible by the remarkable ability of hemoglobin to utilize effectively available oxygen when the atmospheric concentration is reduced.

It should be remembered that an oxygen tension of 95 millimeters mercury in the plasma, which results from the normal 100 millimeters mercury tension of oxygen in the alveoli, produces almost complete saturation of the hemoglobin—actually 98%. Therefore an increase of oxygen concentration to the maximum will increase hemoglobin saturation by a mere two percent. This increase in hemoglobin saturation of two percent increases the oxygen content of the blood very little, actually one-half of one percent. Also hemoglobin will liberate oxygen readily in an area in which the oxygen tension is low, as it is in the tissues.

Therefore, if hemogloblin is exposed to low oxygen tension in the alveoli, a proportionately larger percentage of the available oxygen will be extracted by the hemoglobin and then distributed so as to maintain normal tissue oxygen tension. Thus there are larger reserves available and functioning to protect the tissue oxygen tension.

The oxygen supplied to the tissues does not come directly from the hemoglobin; it comes from the oxygen which is in solution in the plasma. Although this gas is under a

* From the Department of Anesthesiology, Indiana University School of Medicine.

tension of 95 to 98 millimeters of mercury in the arterial blood, in quantity there are only three-tenths of one cubic centimeter of oxygen in solution in 100 cubic centimeters of whole blood. As this oxygen in solution diffuses out of the plasma, it is replenished by the oxy-hemoglobin bank. Therefore, one is ordinarily justified in thinking of available oxygen as that contained in the hemoglobin. However, the plasma is able to absorb approximately 1.7 volumes % oxygen over the normal .3 volumes % when the alveolar oxygen concentration is raised to a maximum. Thus the total oxygen content of the arterial blood is raised about 10%. This factor becomes especially important when one is dealing with the severely anemic patient, or the patient whose cardiovascular system is overtaxed. When oxygen therapy is employed for the patient whose hemoglobin is fully saturated, this oxygen carried in the plasma in solution is the total advantage to such therapy.

Hypoxia a Reliable Indication

Although the etiological factors that result in conditions which make oxygen therapy desirable are many, the final common indication for subjecting a patient to this treatment is tissue hypoxia or impending tissue hypoxia. Therefore it becomes a necessity for the physician to determine when such circumstances exist. Dyspnea, tachypnea, and hypnea are not reliable signs of hypoxia; though, of course, they frequently are a part of the clinical picture.

If carbon dioxide is being eliminated adequately, the oxygen content of the blood may be reduced considerably and there will be no stimulation to respiration as long as arterial oxygen tension remains normal. No tachypnea occurs because respiratory stimulation, as a result of hypoxia, depends on the action of the aortic and carotid bodies. These bodies are not affected by reduced oxygen content (hemoglobin saturation) as long as the plasma oxygen tension is maintained. There is usually no change in the respiratory rate with reduction of oxygen concentration in the inspired air until such reduction reaches 16 volumes %. Even reduction of oxygen in the inspired air to 10 volumes % with a resulting hemoglobin saturation of 73% will stimulate the respiratory rate only moderately. One can appreciate the importance of this observation when we remember that it is rare for the arterial oxygen saturation to be less than 80% in such clinical conditions as congestive heart failure, pneumonia and emphysema.

Dyspnea (the subjective sensation of respiratory embarrassment) is a very unreliable guide to oxygen need, because there is such a tremendous variation in individual response. Dyspnea is usually experienced when one is obligated to breathe at a volume equal to one-half the maximum breathing capacity. In the normal individual this volume would equal approximately 50 liters per minute.

Due to the presence of transudate or exudate in the lungs, the patient in congestive failure may experience discomfort when the minute volume is increased to seven or eight liters per minute. Oxygen therapy will usually decrease this uncomfortable sensation. However many times dyspnea is due to retained carbon dioxide with acidosis and the discomfort may result from alterations of the stretch reflexes in the lungs. An increase in oxygen content of the arterial blood will, of course, fail to relieve symptoms due to these factors.

Cyanosis is also an unreliable guide to the presence of hypoxia or the effectiveness of oxygen therapy. In the normal individual, reduction of the oxygen supply to a level sufficient to allow five grams or more of reduced hemoglobin to accumulate in the arterial blood will produce cyanosis. However it is necessary that such an individual breathe an atmosphere containing 12% or less oxygen before cyanosis will result. In the severely anemic patient, the oxygen content may be quite low without the production of five grams of reduced hemoglobin.

Vascular collapse of the patient in shock may conceal the presence of cyanosis. On the other hand cyanosis occasionally occurs in individuals having adequate amounts of oxygen in their blood. Such cyanosis may be due to peripheral vasospasm, as seen in the patient with Reynaud's syndrome, or in the hypothermic patient. Cyanosis may also

occur without hypoxia in the patient suffering from polycythemia. In spite of these pitfalls cyanosis would be a rather good, though late, guide to the presence of hypoxia if it were not for the fact that cyanosis is so difficult to evaluate. Carefully controlled studies have shown that the detection of cyanosis is perplexing, inconsistant and unreliable in the hands of most physicians.

Pulse Rate is Best Guide

The clinical laboratory can accurately measure the oxygen content of blood. Therefore a sample of blood carefully collected from an artery can be a valuable guide to the need for and the success of oxygen therapy. Realizing however that the determination of the arterial oxygen saturation is not likely to soon become a common practice, it should be mentioned that our best clinical guide to oxygen want is the pulse rate. Although many factors may alter the pulse rate, much can be learned by a study of this parameter. When hypoxia is suspected and one utilizes oxygen therapy, a decrease in the pulse rate of 10 beats per minute indicates that a state of hypoxia has, indeed, been present. On the other hand if one terminates oxygen therapy and then finds the patient's pulse to increase rapidly, the patient should be returned to the oxygen rich atmosphere.

It has been shown that the pulse rate will increase according to the following pattern as arterial saturation of hemoglobin with oxygen decreases. A four percent rise in pulse rate develops when saturation is decreased to 93%. A 10% rise occurs at 80% saturation, and a 30% rise may be detected when arterial saturation is only 70%. It is significant that the pulse will increase in hypoxia even in anemia or carbon monoxide poisoning, in which there is normal oxygen tension but reduced oxygen content. Of course, we must remember that if hypoxia is acute and severe, the pulse rate will slow drastically due to myocardial depression.

Methods of Administration

Once having decided that oxygen therapy is indicated for our patient, the technic by which we deliver this agent is of utmost importance. The common devices used to accomplish the task are the tent, the nasal catheter and various types of masks. The tent can be an effective way of giving oxygen to a patient—affording a means of controlling the temperature around the patient as well as adequately hydrating the inspired air. Furthermore, in contrast to the catheter, the patient's nasal passages are available to help saturate the inspired gas with water.

The disadvantage of the tent is the frequent failure of the operator to increase the oxygen content of the enclosed air space to a satisfactory level. This failure results from leaks that may occur, especially when they are at the bottom of the tent. Oxygen is difficult to contain in these tents because it is heavier than air and therefore occupies the most dependent areas.

An effective way of making the oxygen tent more efficient is to use the "open top canopy." This tent is designed so that only the patient's head is inside the tent. The tent is sealed around the patient's neck. The open top tent leaves the patient's body outside the tent for examination, bathing, etc. The patient can be fed or given oral medication through the open end of the canopy without disturbing the oxygen concentration.

This tent will maintain an oxygen concentration of 50 volumes % on a 10 liter per minute flow of oxygen. The conventional tent, all too frequently, will measure only 35 volumes % or less on the same oxygen flow rate. A flow rate of this magnitude will satisfactorily flush the carbon dioxide from either tent. Carbon dioxide levels in these tents with an eight to 10 liter flow rarely exceed one percent. It should be noted that about five minutes are required before these flow rates significantly elevate the oxygen content of such a tent. While 50 volumes % oxygen is about the maximum one can expect to obtain from the conventional tent, a 15 liter per minute flow into the open top tent will result in the accumulation of a 70% oxygen concentration.

The nasal catheter conducting a six liter flow of oxygen is the least expensive and ordinarily the most practical technic for de-

livering oxygen. Some people will not tolerate a catheter however, especially if they are disoriented or comatose. Also small children and babies frequently will terminate such therapy by one means or another. If one does use the nasal catheter it is well to remember that the placement of the catheter is critical. The catheter must be anchored so that the tip is just below the posterior edge of the soft palate. If the catheter is lower, much of the oxygen may go into the stomach, also the patient will tend to gag. If the catheter is higher, the inspired concentration of oxygen will be reduced due to dilution with the atmosphere.

When oxygen is supplied through a nasal catheter, each liter of oxygen flow will increase the oxygen concentration four percent. Thus a six liter flow will give an oxygen concentration of approximately 45 volumes % to the inspired air. However the maximum concentration of oxygen one can achieve by this technic is 60%. Therefore a flow rate above eight to 10 liters will accomplish nothing, especially since carbon dioxide elimination is not dependent on the flow rate in this situation.

Oxygen therapy by mask is popular in some areas, especially as a means of intermittent, self administration for the patient with chronic hypoxia. If the mask is satisfactorily applied to the face, an effective concentration of oxygen can be obtained with a six liter flow of gas. We have measured the gases under these masks and have been impressed by finding oxygen levels as high as 70%. A flow rate of six liters per minute is the minimal amount one can use and prevent carbon dioxide accumulation. The discomfort of the mask makes it unsuitable for prolonged use.

Humidification a Necessity

It is very important that any oxygen supply be adequately humidified, for normally the inspired air is completely saturated by the time it reaches the alveoli. Humidification must be produced by a nebulizer rather than simply bubbling the oxygen through water. Ordinarily the humidification of room air at 72°F. will rarely exceed 50% relative humidity. The water contained in a sample of such air is only sufficient to register a relative humidity of 19% when the sample is heated to body temperature. Thus to completely humidify the inspired air, about 60 cubic centimeters of water are removed from the trachea, bronchi and alveoli per hour. As a result of this action the mucous secretions in these structures become more viscous and are thus capable of obstructing the passageways.

If a patient is breathing 20 liters of dry gas per minute including six liters of oxygen supplied from a tank, each liter of oxygen will have to carry three liters of water vapor to provide sufficient water to protect the respiratory mucosa. A liter of water vapor contains .05 cubic centimeters of liquid water. Therefore an effective nebulizer must be able to vaporize 60 cubic centimeters of water per hour.

Some nebulizers in use today will deliver 80 to 140 cubic centimeters of water per hour. Although the size of the water particles in the vapor is critical to effectively distribute the water in the lung, we must depend on the specifications provided by the manufacturer of the nebulizer for this information. The ideal particle size for the water vapor is a range of two to four microns.

Summary

Oxygen therapy is the provision of an atmosphere that contains oxygen in a greater concentration than that available in the air. To be effective this atmosphere must be adequately humidified and delivered to the patient in such a way that carbon dioxide is not allowed to accumulate and by a device that is comfortable to the patient.

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Torsion of the Spermatic Cord in the Newborn

DONALD L. FIELDS, M.D.*
ROBERT L. MICHAEL, M.D.†
Kokomo

SCROTAL SWELLING in the newborn may be due to many causes. Most commonly it is due to edema, hydrocele or inguinal hernia. Other causes include: tumor, epididymitis, cellulitis or torsion of the spermatic cord.

Torsion of the spermatic cord is a twisting of the cord on itself with a resultant loss of blood supply to the testis. Gangrene or atrophy of the testis results if the torsion is not relieved. The following case was diagnosed preoperatively as an incarcerated inguinal hernia, possibly strangulated.

Case Report

This male infant was born April 25, 1963 at St. Joseph Memorial Hospital, Kokomo after a full term pregnancy. The mother had mild hypertension and was being treated for pyelonephritis with a sulfonamide drug. She had had three previous uneventful pregnancies and deliveries. The baby was delivered spontaneously from an left occipito-anterior position. The membranes ruptured a few minutes prior to delivery. A prolapsed cord with good pulsations was noted immediately prior to delivery. The infant breathed and cried spontaneously. Examination was entirely negative at the time of birth. Birth weight was nine pounds, six ounces.

Swelling of the scrotum was noticed when the baby was approximately 12 hours old. The infant had no vomiting, irritability or unusual crying. The temperature was 100° (rectally). Examination revealed firm, red swelling with warmness confined entirely to the left side of the scrotum. There was no detectable swelling in the inguinal area. The overlying skin was movable and unthickened. There was no transillumination.

No hernia was found at surgery. There was clockwise torsion of the left spermatic cord which occurred above the tunica vaginalis (extravaginal). The structures beyond the torsion were hemorrhagic. The torsion was relieved, but after several minutes observation there was no improvement in the color. Orchiectomy was then performed (Figure 1). The infant tolerated the procedure well and was discharged from the hospital on the fourth day.

Comment

Torsion of the spermatic cord may be extravaginal, which is usually the situation in a newborn, or it may be intravaginal. It may result from several factors—extra roominess of the tunica vaginalis, long mesorchium, a lax or absent gubernaculum or elongation of the globus minor. Torsion is



FIGURE 1
SURGICAL SPECIMEN fixed in formalin.

* 500 Southway Blvd. E., Kokomo.
† 321 W. Walnut St., Kokomo.

more common on the left side. When on the left side, rotation is usually clockwise. It is usually counterclockwise on the right side. The first year of life is the most frequent time of occurrence and puberty is the next most frequent.

In the newborn there are usually few symptoms, however, fretfulness and restlessness may be observed. Acute torsion in the older individual, however, is attended by sudden, severe testicular pain and swelling. There may be shock. The testicle may be elevated due to twisting and shortening of the cord. There may also be nausea, vomiting and lower abdominal pain. With necrosis, chills and fever may appear. The pain seems to lessen or disappear when gangrene occurs.

Surgical fixation of the untwisted testis should be done immediately. There is a difference in opinion as to whether or not orchiectomy should be done, even with devitalization present. Some feel the testis should be left in for cosmetic reasons. There are also differences of opinion as to whether or not fixation should be done on the unaffected testis to prevent torsion in the future.

Summary

An instance of torsion of the spermatic cord in the newborn is reported. The clinical findings and treatment are reviewed.

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Foot in Door—or Mouth?

Medicine's openly-expressed fear that passage of a King-Anderson-type bill to hang medical care for the aged on the social security system would be the "foot-in-the-door" approach to complete socialization of health care has received unexpected support from the other side of the philosophical fence.

This occurs in a lengthy editorial in the San Francisco *The Dispatcher,* November 15, 1963, a labor organization publication.

The editorial, attacking the American Medical Association for opposing the old folks' "extensive fight for national Medicare," concluded with:

"When even weak half-way measures (i.e.: King-Anderson compromises) are bitterly opposed by medical-money interests labor can do no less than fight for full measures—for a complete health package, today for the aged, *tomorrow for all Americans of every age.*" (Emphasis added).

That certainly spells it out.—Reprinted from *The Newsletter* of the California Medical Assn., Jan., 1964.

Cushing's Disease and Post-Adrenalectomy Hyperpigmentation

WILLIAM S. MULLICAN, JR., M.D.
*Indianapolis**

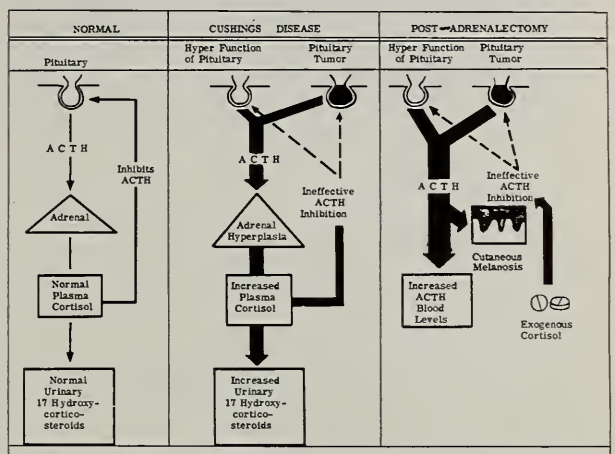
DR. HARVEY CUSHING first described the familiar syndrome that bears his name in 1932. Its association with basophil adenoma led him to assign to it a pituitary etiology.[1] Until recently this classical concept has been overshadowed by the more obvious manifestations of adrenal abnormality. The metabolic disturbances of Cushing's syndrome are the result of excessive adrenal steroids and are accompanied by increased amounts of these hormones and their degradation products in the blood and urine. Functioning adrenal tumors account for 30% of the cases of Cushing's syndrome, and in this situation the relationship is obvious. It is in the remaining 70%, in which adrenal hyperplasia is present, that a pituitary etiology has again been implicated.

Cutaneous hyperpigmentation, such as occurs with Addison's disease, is recognized as a manifestation of pituitary hypersecretion. Its occurrence in a young man after total adrenalectomy for adrenal hyperplasia focuses attention upon the role of the pituitary in the etiology of Cushing's syndrome, and is the subject of the following report.

Case Report

A 27-year-old white male was admitted to the Indiana University Medical Center on 8/10/62 for evaluation of hypertension of two years' duration. During the previous two years the patient had gained 30 pounds and had noticed weakness, easy fatigability and a daily occipital headache. His past medical history was not remarkable.

Physical examination revealed a well-developed, 27-year-old white male with a "moon facies" and truncal obesity (Figure 1). No striae were present. His blood pressure was 240/140, pulse rate 80 and respiratory rate 16. There were xanthelasma present on each upper eyelid and a grade I hypertensive retinopathy. The visual fields were normal. There was no gynecomastia present. The lungs were clear to auscultation and percussion. The point of maximal cardiac impulse was in the anterior axillary line in the fifth intercostal space; A_2 was accentuated and was louder than P_2. There was a question of a protodiastolic gallop. The liver edge was palpable 1½ cm. below the right costal margin. The genitalia were those of a normal adult male, and the neurological examination was within normal limits.



A SCHEMATIC REPRESENTATION OF THE REGULATORY EFFECT OF CORTISOL UPON THE PRODUCTION OF ACTH IN THE NORMAL, AND THE INEFFECTIVE INHIBITION OF ACTH BY CORTISOL IN CUSHING'S DISEASE, BOTH BEFORE AND AFTER ADRENALECTOMY. EXCESSIVE ACTH STIMULATES ADRENAL HYPERFUNCTION TO PRODUCE THE CLINICAL MANIFESTATIONS OF CUSHING'S DISEASE. IN THE POST-ADRENALECTOMY STATE THE CUTANEOUS HYPERPIGMENTATION IS ALSO A MANIFESTATION OF PITUITARY HYPERFUNCTION.

Laboratory: Complete blood count, blood urea nitrogen, urinalysis, electrolytes, and protein bound iodine tests were all within normal limits. A glucose tolerance test revealed a diabetic curve. Serology was negative. Urinary catecholamines by the rabbit aortic strip technic were not elevated, and an intravenous regitine test was negative. The skull x-ray, including the sella turcica, was normal. Intravenous pyelograms were interpreted as being normal. Plasma cortisols, urinary steroid levels and dexamethasone suppression tests (Table I) and an ACTH stimulation test (Table II) were con-

* From the Department of Endocrinology and Metabolism, Indiana University Medical Center. Dr. Mullican is a Research Fellow in Cardiology.



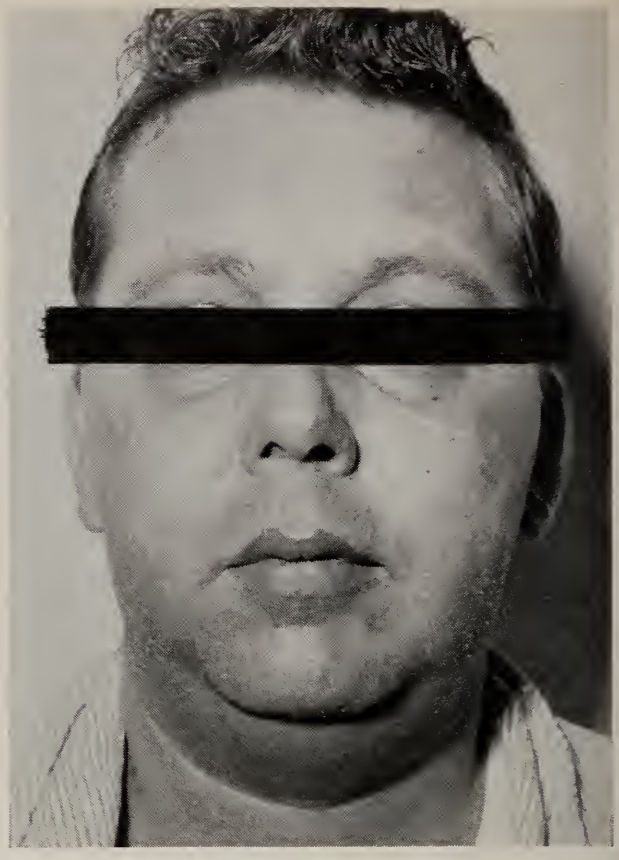


FIGURE 1

CLINICAL PHOTOGRAPHS prior to adrenalectomy show "moon facies" and truncal obesity of Cushing's syndrome.

sidered diagnostic of Cushing's syndrome secondary to adrenal hyperplasia.

Hospital Course: After preparation with cortisone acetate, 100 mg. twice a day for three days, the patient underwent a total adrenalectomy without significant difficulty. The adrenals were grossly normal. The left adrenal weighed 9.7 gm. and the right 10.3 gm. The only histologic abnormality was marked hyalinization of the arterioles. He eventually was maintained on cortisone, 37½ mg. a day, and Florinef, 0.1 mg. a day. On this medication his blood pressure remained in the range of 160/110 and he was discharged to be followed in the Medical Center's outpatient clinic.

On 4/1/63 the patient was re-admitted to the surgical service for removal of a mass under the left nipple, from which he had occasionally experienced drainage of a clear fluid. The patient had previously been placed on reserpine for his hypertension as an outpatient, without significant change in his blood pressure. He again complained of occipital headaches, but in addition had also noted severe bitemporal headaches and stated that increasing pigmentation of his skin had been occurring for three to four months. He had lost approximately 30 pounds since his adrenalectomy.

Physical examination revealed a well-developed, well-nourished white male, with a striking degree of cutaneous pigmentation, especially of his adrenalectomy scar and a skin graft donor site on the right anterior thigh (Figure 2). His blood pressure was 180/100 recumbent, and 180/110 standing. The xanthelasma of the upper lids and the grade I hypertensive retinopathy were unchanged. Visual fields were intact. The point of maximal impulse was 2 cm.

DEXAMETHASONE SUPPRESSION TEST

Day	Normals	Plasma Cortisol mcg/100 ml 8 a.m.	Plasma Cortisol mcg/100 ml 5 p.m.	17-Ketosteroids mg/24 hrs	17-Hydroxy-corticosteroids mg/24 hrs.
		15-30 mcg/100 ml		8-21 mg/24 hrs.	3-9 mg/24 hrs.
1	Control	—	32.2	—	—
2	"	24.0	34.0	—	—
3	"	32.0		8.75	21.80
4	"	31.0		19.00	28.20
5	"	30.0		9.55	25.60
6	Dexamethasone 0.5 mg q6h	28.0		11.95	14.90
7	"	8.5		—	—
8	"	9.5		4.50	8.80
9	Dexamethasone 2 mg q6h	26.0		—	—
10	"	7.0		4.65	4.88
11	"	7.5		2.50	3.78
12	Control	25.0		—	—

RESULTS OF PLASMA cortisol and urinary 17-ketosteroid and 17-hydroxycorticosteroid determinations before and during dexamethasone administration prior to adrenalectomy.

TABLE I

from the midclavicular line in the fifth intercostal space, A_2 was louder than P_2 and there was a grade III aortic systolic murmur. A tender 1 x 2 cm. mass was palpable in the left breast. Seventeen-ketosteroids were recorded as 10.3 mg. per 24 hours, and 17-hydroxycorticosteroids as 1.9 mg. per 24 hours. An ACTH blood level, kindly performed by Dr. Grant Liddle of Vanderbilt University, was 1.5 mU (milli units) per 100 ml. (normal = 0 to 0.5 mU%). Electrocardiogram revealed left axis deviation. Skull x-rays were interpreted as normal. Pathological examination of the breast mass was diagnositic of gynecomastia. The patient was discharged and continues to take cortisone and Florinef as previously.

Discussion

The significance of cutaneous melanosis occurring after adrenalectomy for Cushing's syndrome due to adrenal hyperplasia was first recognized in 1958, when the development of an ACTH-producing chromophobe adenoma of the pituitary in such a patient was heralded by profound pigmentation of the skin.[2] Since then there have been numerous cases of ACTH-producing chromophobe tumors associated with Cushing's syndrome in which the pituitary lesion was evident initially[3-7] or after adrenalectomy [2,4,5,8,9], and in which post-adrenalectomy pigmentation has been a striking feature. Other pituitary tumors, including chromophobe and basophilic carcinomas, and mixed tumors have also been associated with Cushing's syndrome.[3,10]

In some cases, skin pigmentation was a presenting symptom of Cushing's syndrome[1,3,11], and in others, such as the present

ACTH STIMULATION TEST

8 Hr. I.V. Infusions	Plasma Cortisol mcg/100 ml Before ACTH	Plasma Cortisol mcg/100 ml After ACTH	17-Ketosteroids mg/24 hrs.	17-Hydroxy-corticosteroids mg/24 hrs.
Day 1: ACTH 25 u	23	95	6.46	10.85
Day 2: ACTH 25 u	37	112	14.80	54.50
Day 3: ACTH 25 u	33	177	12.70	54.00
Day 4: Control	—	—	11.00	54.00

RESULTS OF ACTH stimulation test prior to adrenalectomy.

TABLE II

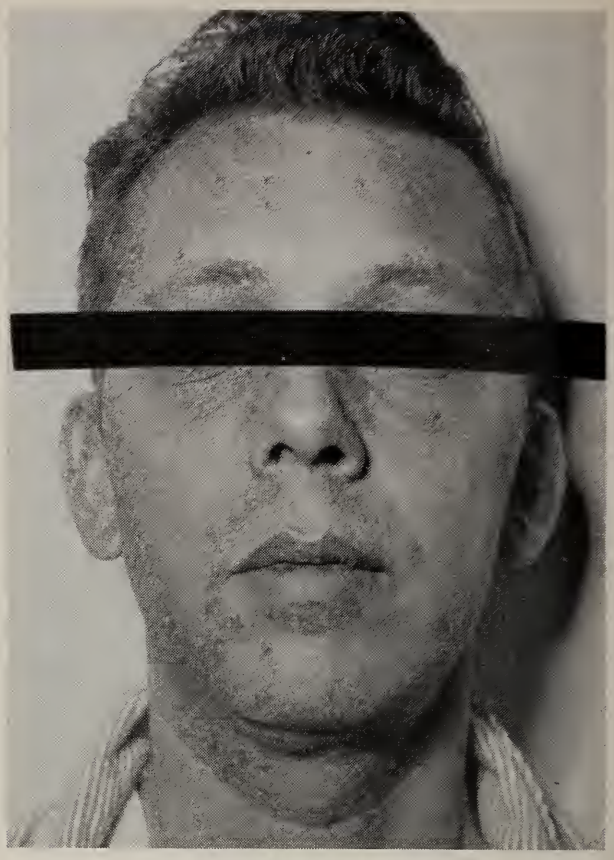


FIGURE 2

AFTER ADRENALECTOMY the patient's appearance is normal except for hyperpigmentation which is not well seen in these photographs.

case, post-adrenalectomy pigmentation has been reported without visual field or x-ray evidence of a pituitary tumor.[8,12] It should be pointed out, however, that in one reported series an average of three years elapsed after adrenalectomy before a pituitary tumor was demonstrated.[8] It is therefore possible that a pituitary lesion may yet develop in the future in some of the unaffected patients.

The pigmentation of the skin is a manifestation of pituitary hyperfunction, and has been shown to be correlated with overproduction of MSH (melanocyte stimulating hormone) and ACTH.[11] These two pituitary hormones are similar in structure and amino acid sequence. It is, therefore, not surprising that MSH has some adrenocorticotrophin activity and that ACTH, in its most purified state, has the ability to produce melanin pigmentation. This has been confirmed by the finding of increased ACTH blood levels in the Addisonian and the post-adrenalectomy Cushing's patient.[8,13]

Although the amount of cortisol administered and the plasma cortisol levels may be comparable in these two categories of patients, the ACTH blood levels are consistently higher in the post-adrenalectomy Cushing's patient[13], and less responsive to suppression with exogenous hydrocortisone.[8] This patient's ACTH blood level of 1.5 mU per 100 ml. is definitely elevated. It does not, however, approach the extreme value of $>$ 400 mU per 100 ml. reported in one case of an ACTH-producing chromophobe[2], and, in fact, is only slightly higher than is found in Addisonian patients receiving cortisol replacement.[13] Characteristically the Cushing's patient, whose cortisol levels have returned to normal after adrenalectomy, has an elevated ACTH blood level, whether a pituitary lesion is established or not.[13] This

observation reinforces the notion that Cushing's syndrome due to adrenal hyperplasia is the result of excessive ACTH production. Decrease, or disappearance, of skin pigmentation is often accomplished in the Addisonian by adequate steroid replacement, but adequate, or even excessive, replacement fails to produce a similar result in the Cushing's patient who becomes pigmented after adrenalectomy.[4] The observation that, in some instances, the pigmentation has regressed following hypophysectomy or pituitary irradiation[2,8,11] further emphasizes the role of pituitary hypersecretion in the production of post-adrenalectomy pigmentation.

Hyperpigmentation associated with Cushing's syndrome has recently been reported with an ACTH secreting "non-endocrine" mediastinal tumor. The hyperpigmentation occurred simultaneously with the recrudescence of Cushing's syndrome in a patient who had previously had a subtotal adrenalectomy, and both regressed after removal of the mediastinal tumor.[14] Excessive adrenalocorticotrophin, whether of pituitary or "non-endocrine" tumor origin, is therefore capable of inducing cutaneous pigmentation as well as adrenal hyperplasia and increased cortisol production.

In those cases in which a pituitary tumor is discovered after adrenalectomy, it is believed that the pituitary tumor is present, but not demonstrable, prior to surgery. Adrenalectomy is apparently not the cause of the pituitary tumor, since none has been reported following such a procedure for the palliative therapy of cancer or hypertension[5], but it does seem to favor the growth of the pituitary neoplasm.[4,8,11]

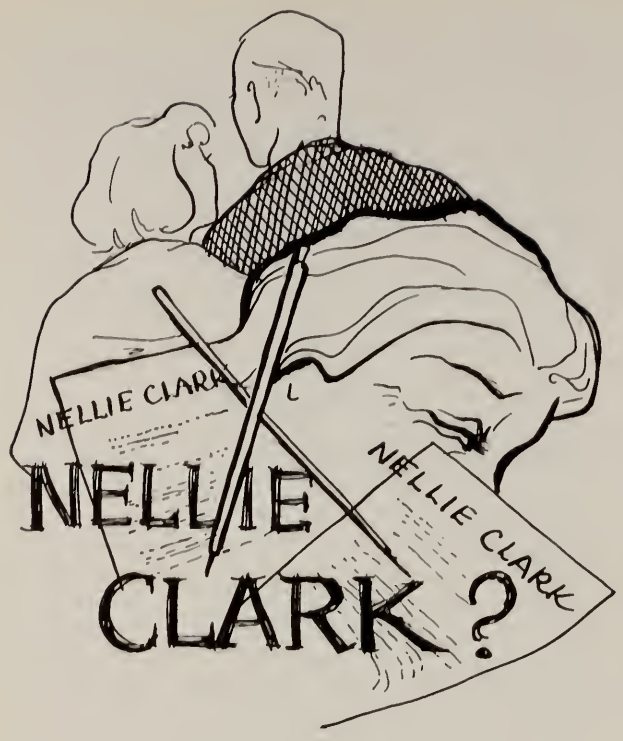
Summary

A patient in whom cutaneous hyperpigmentation occurred shortly after adrenalectomy for Cushing's disease is presented, and hyperpigmentation, as a manifestation of pituitary hyperfunction, is discussed. In this case there is no evidence of a pituitary neoplasm, and the ACTH blood level, though elevated, does not suggest such a tumor at this time.

Cutaneous melanosis occurring in the post-adrenalectomy Cushing's patient has been a significant feature of ACTH-producing chromophobe adenomas of the pituitary. Hyperpigmentation under such circumstances is not always an indication of a pituitary neoplasm, but its occurrence either before or after adrenalectomy should alert the physician to this possibility.

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The Case of Compounded Confusion

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MORE THAN ONE horrendous example of malpractice has been rooted in the *correct* order being written on the *wrong* chart! Then should *TWO* Nellie Clarks attend the same clinic at the same time for approximately similar ailments—is there an easier way of confounding the most conscientious clerk? But: let us start from the beginning.

Our particular Nellie Clark came from the backwoods of Appalachia, up a "holler" not far from the abandoned tipple of an exhausted coal mine. We are proud of our exertions in behalf of deprived natives—even the cannibals at the headwaters of the Sepik river in New Guinea have seen members of our Peace Corps. I wonder why we are so remiss in doing something to restore a little human dignity to the woebegone descendants of our once proud, pioneering mountaineers—the stock of Daniel Boone and Davy Crockett? They do get handouts of surplus foods, but does that permit us to forget their lack of basic housing, the most elementary of plumbing, lack of medical care, hunger? No effort is made to retrain the obsolete coal miner for a new job! Where is the vaunted American ideal of the *right* to the human dignity of rearing a family and giving one's children a future?

Anyhow! Nellie Clark had been crushed by knowing only grinding penury. The flimsiest of shacks that let through the heat of summer and the blasts of winter. The outdoors for a latrine; water to be carried from the stream in pails; never enough to eat; no schooling; not even a nurse (let alone a doctor) ever came to the cluster of sagging lean-to's that comprised the village where she was born. Bearing children to a husband that brought a pay check home but rarely. Never glimpsed by the world that passed by quickly on the highway some miles down the valley.

Came the Korean "police action" and a son got drafted! I do wonder how they found him. The young man went abroad and got a look at the outside world. When discharged, he fled the dismal domain of the past with no future; he went to Brooklyn and got a job as a laborer. His widowed mother came with him; they kept house in a condemned, rat infested, cold water flat unrenovated since its construction back in the days of Boss Tweed. Still, there was a functioning faucet—to say nothing of a toilet *and* a bathtub—only one flight up the stairs and down the hall! A horror by city standards but much better than what Nellie Clark had left behind.

Progeria and Poverty

Some years went by. The son got involved in a strong arm brawl between a couple of warring unions being absorbed by the Cosa Nostra. An enforcer bashed in his skull; this left the man "weak in the head." After his commitment to a V.A. facility, Nellie Clark was left alone, living on a little Federal pension supplemented by city relief.

In 1960, Nellie was sent to the largest municipal hospital of the borough. Back in her "holler," she would have died of the attack of pneumonia. In the city, she was cured BUT: the penicillin she was given sensitized her to that beneficent but dangerous drug. Somewhat recovered, she was discharged to the outpatient clinic. Still in her forties, she looked twice her chronological age. She received treatment for high blood pressure and premature hardening of the arteries. The digitalis and rauwolfia helped but the quinidine had to be discontinued because of bad reactions. A mild diabetes responded to oral hypoglycemic agents.

In the spring of 1962, Nellie suffered a mild stroke; again, she was given hospital care. She recovered only partially. Unable to care for herself, she was relegated to a nursing home: true human flotsam, life's wastage! In the fall of 1963, the weekly medical inspection noted her to be, "feverish"; there were rales at her lung bases; the blood pressure was elevated, the heart irregular, the hemiparesis seemed worse and her speech was slurred. She got a big slug of penicillin that day and the next; also aspirin and digitalis. Not seeming to improve, she was transferred to still another hospital.



. . . knowing only grinding penury.

One of my nice, new residents saw her on admission. He noted a "markedly dehydrated, very ill, poorly developed white woman seeming much older than her stated age." He confirmed the pneumonia, heard the atrial fibrillation and read the nursing home note stating that Nellie Clark had been a patient at the other hospital. Being a very capable, conscientious and dedicated young doctor, he went to the time-consuming procedure of phoning this other institution. The librarian was very obliging; yes, they had Nellie Clark listed as a patient both in the hospital and the outpatient clinic. What had she been treated for? Why, high blood pressure and arteriosclerosis. What had been given? Digitalis, quinidine and a tonic. The gracious young lady would mail a confirming letter that very day.

The newly admitted patient had some routine entrance examinations performed immediately even if the diagnosis seemed to be reasonably certain. The x-ray showed some right lower lobe consolidation; spinal tap gave clear fluid under normal pressure; the hemoglobin was horribly low and the white blood count was 15,000 with a shift to the left. The electrocardiogram confirmed the atrial fibrillation and myocardial anoxia suggestive of an old infarct. The blood pressure-180/100, temperature-102°, respiratory rate-24. Continuous intravenous fluids were started; she was sponged for her fever and given Terramycin orally. Because the EKG raised some questions as to possible digitalis toxicity, she was started on 200 mgs. of oral quinidine, t.i.d.

Nellie did fairly well that day and the next. Although the urine showed pus and

many bacteria, the fever defervesced and, though still lethargic, she started taking nourishment by mouth. Just as the day shift was coming on at the beginning of her third hospital day, there was a sudden, dramatic and precipitous fall in Nellie's blood pressure. As she went into shock, Nellie became unconscious. Within another hour, every orifice of her body began oozing thin, almost watery blood!

The Nascency of Knowledge

ALLERGY is an enormous topic with an exciting future. Nobel prizes are being won as its mysterious crannies are being probed. It is hard to remember that it is not too many years ago that the human ovum was first seen. It is a microscopic sphere 1/300th of an inch in diameter. The nucleus of this single cell has the chromosomes carrying in their nucleic acids the five billion genetic sub units that spell out our entire heredity! The language is in four letter "words" of three repeating DNA or RNA units. There are only 64 possible letters but that makes possible 1.7×10^9 three letter words of 64 varieties. This is another way of saying that the directions for building a single human being are the equivalent of one thousand volumes of information written in English: each book composed of 600 pages, 500 words to the page! All this nucleic acid could be placed in a monomolecular layer over one percent of the head of a pin. The complexities of the infinitesimally small makes Albert Szent-Györgyi predict that the application of wave mechanics to biology is already beginning! " . . . Our present knowledge will then open the way to the understanding of the deepest problems, the nature of life, how it originated and perfected itself."

The 21 aminoacids and the four nucleic acids make up the helices of the DNA and RNA with absolute, replicating fidelity: that *is* the genetic code! Now and then, however, there is an error; we have learned to call this a mutation. Most of them are harmful and end lethally. X-rays and atomic fallout accelerate the process (See "The Case of Gender: Dubious," *JISMA* 55:8, 1165-1170, 1962.) Some genetic errors are harmful but the fetus survives. Already, literally hundreds of such diseases are known. We do *not* improve the human stock by exerting our medical ingenuities in having these weaklings live and procreate; this, however, is an ethical problem for another day. However, a rather small percentage of the mutations *improve* the breed: this is the very basis of organic evolution. Szent-Györgyi's speculations re wave mechanics go to the very crux of Einstein's "Beautiful Order of the Universe."

It is essential to individual survival to have a species specific mechanism for keeping foreign nucleic acids out of the chromosomes peculiar to that particular breed. Otherwise, the genetic message would be garbled by every wandering nucleic acid insinuating itself into the cell nucleus. In Burnet's words, "the body learns to recognize self and reject non-self." Just yesterday, the thymus was an insignificant, vestigial gland: an irritating enigma. Albert Szent-Györgyi has achieved the partial isolation of no less than three substances from this very gland: he thinks that one helps to suppress malignant growth, another helps to maintain youthful vigor and the third prevents conception. If true, most interesting! And, of course, Burnet was awarded his Nobel prize for showing that the thymus is the parent gland for all lymphocytes even if, with maturity, they migrate to the spleen and lymph nodes. It is these cells that produce the *antibodies* against the foreign protein, i.e., the *antigen*. The antigen-antibody reaction is at the very heart of the IMMUNE response. This is the everyday method used by nature to kill or neutralize bacterial invaders. Viruses present an additional special problem. We are still in the first stages of comprehending that story.*

* There is a recently discovered, rather low molecular weight substance that has been christened "interferon." Body mechanics seem to produce it as a sort of front line, non-specific barrier to viral invasion of any sort. Apparently, it chelates at the sensitive sites of the naked virus nucleic acid proteins; this prevents viral replication. IF cancer is really due to viruses, interferon must be a factor in barring *infective heredity*, i.e., penetration of the viral proteins into the genes and thus INFECTIVELY altering the hereditary codes.

Now, when antibodies become attached to cells and antigens react with them, disturbances can occur that are very harmful to the host. This is termed the allergic or hypersensitive reaction†. We are still unable to decipher the even approximate macromolecular formulae depicting the complexities of this process. Still, ever more intelligent questions are being asked. Thus, we have found that histamine and serotonin are discharged from mast cells. Monoamine oxidase inhibitors can slow the release of serotonin; antihistamines (note the very word) ease the impact of histamine discharge. Nitrogenation of the cell surface will block the release of phospholipase A: the resulting anoxia of the mast cell membrane prevents the surface alterations that lead to histamine liberation! Does this have any connection with Linus Pauling's intriguing theory of the physics underlying the induction of anesthesia? These random remarks ignore the subject of auto-immune diseases: a vast terra incognita all by itself.*

A Fatal Fallacy

Be all this as it may, Nellie Clark sank rapidly and was obviously in imminent danger of bleeding to death. A bedside laboratory study startled us by revealing the *total* absence of thrombocytes, blood platelets! A whole medical team became very busy doing its level best. Just about this time, the resident received the letter from the obliging librarian—written as promised, two days ago. He gave it to me. The address did not jibe: same street but a different number. The age was slightly different. And THIS Nellie Clark had gone home with a definitely alive husband! A hurried check sickened us with the realization that OUR Nellie Clark was not THIS Nellie Clark. Of course, the clinic numbers also differed.

I was proud of the coordinated, purposeful efforts lavished by the dedicated team of doctors and nurses. Thrombocyte and packed red blood cell transfusions were poured into Nellie Clark's veins. She received vasopressors, oxygen, vitamin K and the whole gamut of medicaments that might have—no matter how remotely—served a useful purpose. Further phone calls brought forth the correct Nellie Clark's history; that is how we became aware of her background including the all-important facts anent her allergy to both penicillin and quinidine.

Putting it mildly, correct orders had been written on the wrongest possible chart. Fortunately for our consciences, we had not given the patient either one of the two injections of penicillin that she had received. Penicillin is a great boon, of course. It is also a notorious sensitizer and every year it kills thousands; disabling reactions reach astronomical figures. That is why doctors refuse to administer the drug indiscriminately; today we question closely every potential recipient as to whether there have been previous side effects.

Quinidine is a much less hazardous substance. It is quite true that it can produce unpleasant reactions: that is why we are in the habit of starting with small doses. We then work our way toward effective therapeutic amounts. The 5th edition of Wintrobe records only two instances of fatal reactions to this most useful drug.

Our Nellie Clark had had the two doses of penicillin before her admission to our institution. The quinidine had been started in test quantities following completely accepted procedures. Whether we were dealing with a delayed penicillin anaphylactic phenomenon or whether we had a more acute quinidine thrombocytotoxic reaction is rather hard to say. Really, the speculations are esoterically academic: remote

† E. A. Kabat in 11th edition of Cecil-Loeb, *Diseases of Allergy.*

* Attention should be drawn to "runt disease." "Self" rejects "non-self"; this is the barrier preventing transplantation of homologous tissues such as skin, kidneys, liver and other glands. The mechanically perfect transplant functions smoothly at the start; then, host lymph cells invade the "non-self" tissue and—within three weeks or less—complete the job of destroying the foreign elements. Dr. Peter B. Medawar has demonstrated actively acquired tolerance by injecting spleen cells into fetuses or newly born animals. When new born animals are injected with adult spleen cells (or very large "non-self" skin grafts), the essential result is that the GRAFT proceeds to reject the HOST! The animal fails to grow properly; this stunting of development gives the condition its name: "runt disease."

from practical reality. With Nellie Clark, the outcome was really preordained, and we knew it, in spite of our dogged perseverance to the very end. Quietly and unobtrusively, just as she had lived her life, our patient expired early in the afternoon; she never rallied from her shock state: blood pressure never could be recorded. Before the body left the ward, note was made of the massive fresh subcutaneous ecchymoses and hemorrhages visible on all body surfaces.



"Death Comes to Set Thee Free"

There was no one to claim the body so that it went to one of the medical schools. Of course, the sticky question of negligence and malpractice was never raised. The dismal life of the perpetual drudge and slavey ended, in the shadows, with a quiet sigh. It seems that our vaunted democratic freedoms include the "right" to toil primitively, be hungry, "live" in travesties of homes, rot in ignorance and die by accidental error. Nellie Clark certainly personified the very bottom level of the "ill-clothed, ill-fed, ill-housed" one-third of the nation in whose behalf F.D.R. made so stirring an appeal—lo, these many decades ago!

Worn-out and discarded by careless, negligent fate, she found peace only in death. I might add that our weekly conference and the medical students benefited very much indeed from the macabre death and the frank discussion of the case. I wonder! Is there a moral in all this?

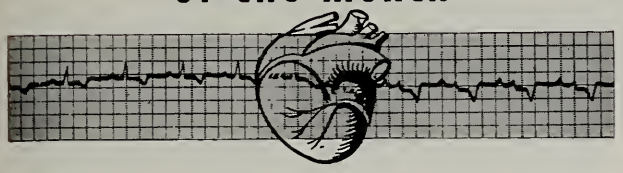
1270 Fifth Avenue
New York N. Y. ◄

Death Behind the Wheel

The leading cause of death in this country today is cardiovascular disease; the second is cancer, but close behind are deaths due to automobile accidents if figured on the man-years of life lost.

The first two are primarily diseases of the older age groups, whereas, the death rate from automobile accidents is highest in youth.

Electrocardiogram of the month



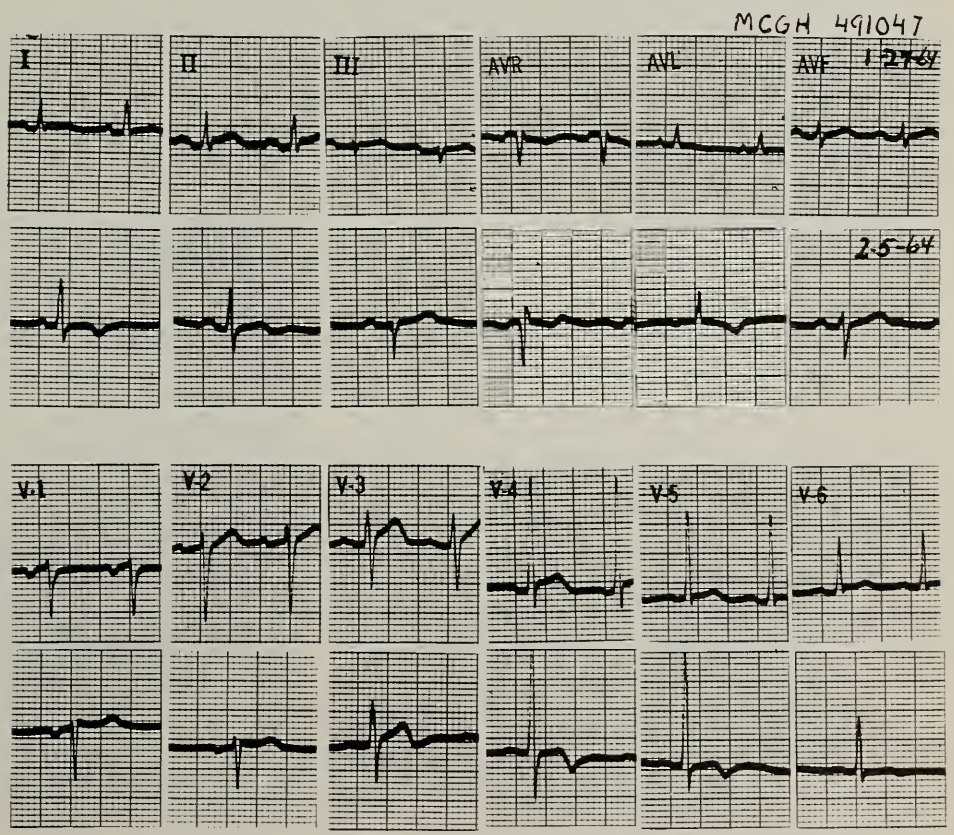
Presented as a regular feature of The JOURNAL, Electrocardiogram of the Month is a series of short talks on cardiovascular diagnosis and treatment, edited by the staff of the Krannert Heart Research Institute, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis.

Pericarditis

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Indianapolis

PERICARDITIS as such produces no demonstrable changes in the electrocardiogram. Only when a subepicardial portion of the myocardium is involved do the EKG manifestations of "pericarditis" become apparent. It becomes clear therefore that pericarditis can exist in the presence of a normal EKG, the EKG may show rather transient alterations or the changes may be quite subtle. The present tracing is an example of the latter.

The patient was a 38-year-old male who was admitted with a history of chest pain which was aggravated by swallowing, breathing and motion of the thorax. The examination was negative except for a pericardial friction rub. The EKG obtained on 1-27-64 showed a minimal elevation of S-T segment in I, II, V3-V6. A depression of the atrial repolarization segment Ta is seen in leads I, II, V4, V5. These changes are so subtle that they could very easily be overlooked. A repeat tracing on 2-5-64 shows unequivocal evidence of evolving pericarditis, namely inversion of T waves in leads I, AVL, V4-V6.



NOTE THE MINIMAL S-T and Ta segment shift on 1-27-64 and inversion of T waves on 2-5-64.

X-RAY CONFERENCE

Presented as a regular feature of *The Journal*, X-ray Conference is a series of short talks on procedure and radiologic diagnosis, edited by Erich K. Lang, M.D.

Subarachnoid Cyst of the Posterior Fossa

*ERICH K. LANG, M.D.**
Indianapolis

A 4-YEAR-OLD white female was admitted to Methodist Hospital with a history of progressive deterioration probably secondary to a posterior fossa lesion. The patient had been asymptomatic till some four weeks previously. Ataxia and nuchal rigidity were the first abnormal manifestations. Some ten days prior to admission, nystagmus was first observed. During the last week the cerebellar signs became more pronounced. Marked nuchal rigidity and a grade three papilledema was observed by the referring physician some 24 hours prior to the present hospital admission. At no time was there any suggestion of an encephalitis, meningitis or significant temperature elevation. The history and clinical examination suggested a space occupying lesion in the posterior fossa.

An air ventriculogram showed a marked internal hydrocephalus. The third ventricle was, likewise, markedly dilated but did not appear to be significantly displaced. The aqueduct and fourth ventricle failed to visualize.

A Pantopaque ventriculogram was subsequently carried out. The Pantopaque column was manipulated, under fluoroscopic control, into the posterior third ventricle and into the aqueduct. Anterior displacement of the aqueduct and fourth ventricle was readily demonstrated. The fastigium of the fourth ventricle appeared to be flattened. There was also some pressure against the infra- and suprapineal recess of the third ventricle. A midline space occupying lesion posterior to the vermis in the cisterna magna was thus postulated. Exploration revealed a huge subarachnoid cyst compressing the cerebellum from posterior and herniating the pons and anterior cerebellum through the tentorium.

* Radiologist, Methodist Hospital.

Discussion

The currently employed contrast studies, air ventriculography or air posterior fossa cisternoventriculography usually fail to precisely localize surgical lesions of the posterior fossa. Pantopaque, when introduced into the ventricular system, permits excellent visualization of the fourth ventricle. A precise pre-operative localization of pos-

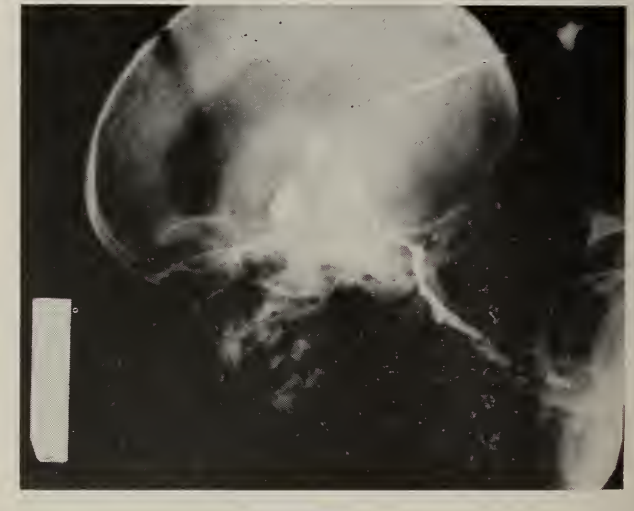


FIGURE 1
NOTE THE MARKED ELEVATION and anterior displacement of the Pantopaque filled fourth ventricle. Pressure against the fastigium and marked deepening of the posterior fossa is apparent.

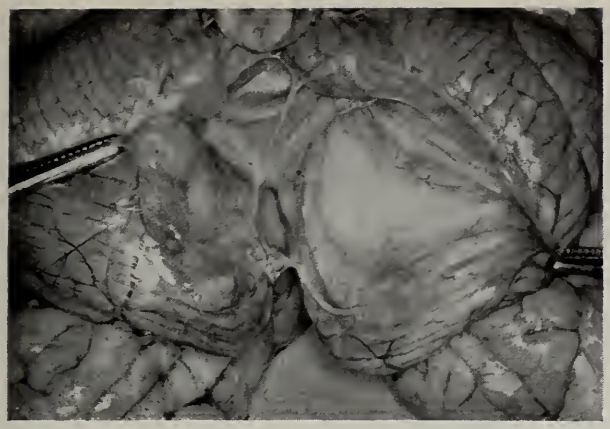


FIGURE 2

THE GLISTENING LINING of the subarachnoid cyst is evident on the specimen. The cyst contained approximately 150 cc. of fluid.

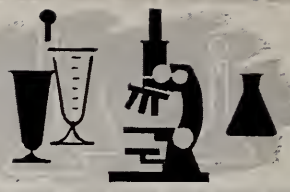
terior fossa lesions is thus possible.

The technic is simple and utilizes fluoroscopic control in the manipulation of the dye column. The examination is best carried out under local anesthesia since the cooperation of the patient on various maneuvers will facilitate the control and movement of the dye column through the posterior third, aqueduct and fourth ventricle. Even minute intra-ventricular lesions are readily diagnosable by this method. No untoward effects have been observed. The Pantopaque may be recovered by spinal puncture. Dye remaining in the ventricular system for a considerable time shows no untoward effects and may thus opportunely be removed at the time of surgery. ◄

Value of Pharmaceutical Industry

The public must understand that the pharmaceutical industry is life-saving and as such fulfills a public function of very great importance. Let it be clearly understood that I refer here, of course, only to those industrial organizations which are actively concerned with drug research and production. This type of industry is essentially productive, and not parasitic, in nature and one of the most positive assets to our form of society. Unfortunately, this is not the image of the pharmaceutical industry in the public opinion and it is time that those whose job it is to influence public opinion should understand these basic facts and take energetic, appropriate measures to get it corrected. I cannot visualize how the industrial pharmaceutical research laboratory could adequately be replaced by any other non-industrial structure, and those who wish to abolish it by nationalization for theoretical reasons, or impede notably its freedom of action, must know that in taking such steps they are conjuring up a major health hazard, much more dangerous than a virulent epidemic. No pharmaceutical industry—no new drugs; this, in a nutshell, is the situation.—*The Trueman Wood Lecture* by Ernst B. Chain, F.R.S., The Royal Society of Arts, London, June 19, 1963.

Path-finder
PUBLISHED UNDER THE AUSPICES OF THE INDIANA ASSOCIATION OF PATHOLOGISTS



Detection of Pre-invasive Carcinoma of the Cervix (Carcinoma-in-Situ)

LEON L. BLUM, M.D.
Terre Haute

CARCINOMA OF THE CERVIX, formerly claiming so many victims among younger women and causing endless suffering, can be conquered. It can be cured by relatively simple means if recognized in the pre-invasive stage, not visible on clinical examination. The value of routine cytology smears ("Pap" smears) in the so-called "high risk" age group (30-45) has been firmly established.

During the past year we detected cytologically and confirmed histologically 37 cases of cervical carcinoma-in-situ corresponding to an incidence of 5.7 per 1000. The technic of obtaining satisfactory smears is well known but there are differences of opinion regarding the relative value of various technics and the number of smears to be taken routinely from each person.

For detection of carcinoma-in-situ of the cervix, we prefer the cervical scraping smear but the exclusive use of cervical scraping would fail to detect carcinomas arising from other sites of the female genital organs, such as endometrial carcinoma.

The following technics proved satisfactory:

1. Two smears per person: a) scraping of squamo-columnar junction with a wooden spatula b) vaginal pool swab
2. Single combined vagino-cervical smear consisting of mucus from posterior vaginal pool and scraping of endocervical canal (recommended by Dr. J. K. Frost of Johns Hopkins Hospital).

Recently another promising method has been added in the form of the so-called "irrigation smear" obtained with disposable Davis' cytopipette or its modification. This technic, introduced in Denmark and now under investigation in the U.S.A., offers a means of reaching young women in the "high risk" group who do not consult the family physician or gynecologist for a routine asymptomatic pelvic examination. Our own preliminary observations are favorable.

With increasing use of gyne-cytologic smears by non-gynecologists some "routine" recommendations for evaluation of atypical or positive cytology smears (Class III, IV and V of Papanicolaou classification) appear indicated. I would like to emphasize, however, that in all such cases the individual patient will derive maximum benefit only by the closest cooperation between clinician and pathologist to determine the significance of cytopathologic abnormalities as applied to that particular case. With this limitation in mind, an outline has been prepared in simplified, easily digestible form (Table I). It must be further emphasized that it applies only to the *asymptomatic* female. Women showing any suspicious lesions should receive immediately the benefit of a conventional tissue biopsy. Many invasive carcinomas do not exfoliate cells as easily

future even if industrial pay remains the same. If industrial pay goes up, hospital pay will go up even more.

Industry can go to automation to reduce manpower costs; hospitals have practically no potential for automation. While 62% of the budget of a hospital is payroll, only about 25% of an industrial budget is for personnel. A comparable payroll raise in industry produces little effect on total cost as compared to the same raise in the hospital.

The basic message in Mr. Brown's discussion is for the doctor. He points out that doctors are "getting lumps" for something that they cannot control. He advises that we all educate our patients (the public) on the economic facts of life. When people complain about the high cost of hospitalization, it is easy to blame other doctors and overutilization, or the hospital administration, or the high cost of hospital supplies. It is easy to blame these things but it is not factual.

As a matter of fact there is no blame in the usual sense of the word. The rise in hospital costs is reasonable and not due to any fault. Costs will continue to rise. Everyone should be acquainted with this fact and the reasons behind it, and should be impressed with the fact that even with the high cost the improved results make it the biggest bargain we have today.

Advertising and particularly pharmaceutical advertising is an essential component of any medical journal. A major portion of the financial budget of *The Journal of the Indiana State Medical Association* is derived from advertising. Advertising in general is therefore essential in a financial sense. Advertisements for drugs and other therapeutic agents are also essential from an educational viewpoint.

Important drugs and especially newly-introduced drugs are described in advertisements in such a way as to make a state medical journal equivalent to a preview of the Pharmacopeia for next year. Readers are urged to consult the index of advertisers each month and tell detail men that you appreciate the advertisements of their companies; and if there are any whose company's advertisements do not appear, ask the detail men to arrange for such advertisements.

Labeling Prescription Drugs

SHOULD A PRESCRIPTION drug label carry the name of the drug? This is a custom which has developed recently. For reasons as outlined below some physicians believe that, at least in some instances, the patient is benefited by having the drug identified by name. For other reasons, as outlined below, other physicians feel that drugs should not be identified.

In some parts of the country the matter is settled by making it customary for the pharmacist to label the drug, unless the physician indicates that he does not wish this done.

In Indiana the opposite custom has been adopted. Feeling that such an important matter as labeling should not be determined by omission of instructions, both the Indiana Pharmaceutical Association and the Indiana State Medical Association, in independent decisions, have determined that no drug shall be labeled unless the prescription carries specific instructions to do so.

This is a sound regulation. It allows those prescribers who wish the drug labeled to have this done with a simple instruction. It also allows all those who do not desire the labeling to avoid it without the necessity of writing anything additional on the prescription.

Those who oppose the labeling of drugs feel that medication is more effective when presented as an unknown, or that this is true when the drug is relatively inert or is given as a placebo. Double blind investigations would be impossible if all drugs carried their true name. There are times, especially in psychosomatic illness when the nature of the medication is best not known to the patient. Also, some patients, with the popular news stories of medicine and drugs as they are, might fear the complications if

they were acquainted with the treatment. Some feel that the labeling of medicines will encourage self-treatment and medicine trading between patients.

Those who favor labeling point out that the public is more erudite today. Patients know more about the details of their diagnostic procedures, the nature of their diseases and the rational of their treatment than ever before. They do better when they know what drugs they are taking.

Other advantages pointed out for labeling are that it makes the identification of a drug reaction or the continuation of treatment by a second doctor much easier. It is helpful when a patient is being treated for more than one condition by more than one physician. If the patient is seen at home, the doctor does not have to rely on his memory or send for his office record to identify his own medicine.

The main point of this editorial is however, that whichever side you are on in Indiana, you can have it the way you want it, with a slight notation in one case and with no notation required in the other.

AMA Announces Highlights of June Convention

THE AMA COUNCIL on Postgraduate Programs has announced that the scientific program for the 113th annual convention in San Francisco, June 21-25 is virtually complete, and that an attendance of between 15,000 and 16,000 physicians is anticipated.

When the AMA held its last convention in San Francisco, in June, 1958, the total physician registration was 13,997.

Dr. J. Arnold Bargen, Temple, Texas, chairman of the Council on Postgraduate Programs which plans the scientific programs for the association's two conventions, the annual and clinical, said that the San Francisco program will be most comprehensive, including lectures, scientific exhibits, preview showings of medical films, and color television.

"The combined efforts of many people, particularly the section secretaries, have helped to formulate a program that will be an outstanding contribution to graduate medical education," Dr. Bargen said.

Dr. John Hickam, Indianapolis, chairman of the program planning committee of the council, said that the following general scientific meetings have already been coordinated by section secretaries:

Differential Diagnosis of the Liver and Pancreas; Hyperbaric Oxygen Phenomena; Computers in Medicine; Autoimmune Mechanisms and Disease, Cardiovascular Opacification and Tumors of the Endocrine Function.

In addition, a special half-day program on various aspects of heart disease will be offered by the American College of Cardiology and the American Heart Association.

The popular and interesting Research Forum program, under the chairmanship of Dr. Edwin H. Ellison, Milwaukee, will be offered again at the San Francisco Meeting. Sixty papers, based on new and original work being done in the nation's medical schools, will be delivered by young, outstanding researchers. In contrast to previous forums, one or two major areas of research, possibly organ transplantation and hyperbaric oxygen in the treatment of disease, will be covered in a symposium presentation.

A general scientific meeting program that has already elicited considerable interest is the half-day session on Hyperbaric Oxygen Phenomena—the science of administering oxygen at super atmospheric pressure.

Principal investigator of hyperbaric research is Dr. Claude R. Hitchcock, chief of surgery at Minneapolis General Hospital and professor of surgery at the University of Minnesota. He and three other Minneapolis surgeons—Drs. John J. Haglin, Russell H. Harris and Frank E. Johnson—as well as other researchers throughout the country, were attracted to hyperbaric therapy by two articles appearing in *Surgery* in March, 1961. The author was Dr. I. Boerema of Amsterdam, Netherlands, whose human-size hyperbaric chamber has been in use since 1959.

Dr. Kenneth K. Keown, anesthesiologist from the University of Missouri Medical Center at Columbia, who is serving as the coordinating secretary for the hyperbaric

program, has plans underway to bring Dr. Boerema to the San Francisco convention.

At the present time, research uses for the hyperbaric chamber are many. Applications where research is expected to be highly productive include acute coronary occlusion, acute carotic artery occlusion, acute intracerebral vascular occlusion, acute cerebral hemorrhage with rupture of berry aneurysm, irradiation, traumatic shock, pulmonary edema and cardiac defect surgery.

All of the 21 sections, representing various specialties in medicine, are formulating interesting and educational programs for the San Francisco convention. Subjects include toxicants and insecticides, chronic ulcerative colitis, psychiatry in general practice, gynecology for the general practitioner, ecology to closed environments (submarines and space craft), basic courses in hand surgery and common foot problems, prosthetics, differential diagnosis of the liver and pancreas, management of lower extremity amputees in the light of recent research, procedures for the treatment of anorectal diseases, and contamination and infection of the bladder and kidney.

San Francisco's Civic Auditorium has been completely modernized at a cost of more than seven million dollars and will be ready for the AMA convention in June.

The AMA scientific exhibits will be set up in the auditorium. The exhibit hours will be 8:30 a.m. to 5 p.m., Monday through Thursday and 12:00 noon to 5 p.m. on the opening day, Sunday. The industrial exhibits will occupy adjoining Brooks Hall under the north half of the Civic Center Plaza.

San Francisco, in keeping with its growing attractiveness as a vacation and convention center, has increased its housing capacity since the AMA last met in the Pacific coast city six years ago. Several major new hotels have been constructed, existing ones have greatly expanded their accomodations, and hundreds of fine motels now encircle the entire bay area. Complete forms for hotel reservations, as well as for advance convention registration, appear periodically in all AMA publications. The entire scientific program and all essential information for attendance will be published in the Convention Issue of *The Journal of the American Medical Association* on May 9.

Guest Editorial

A Remarkable Document

PRESIDENT JOHNSON'S health message is a remarkable document of inconsistency and misinformation on health care for the elderly.

Mr. Johnson declares that elderly Americans should not be subjected to a test of need for tax-paid medical care, but at the same time he urges all states to enact adequate Kerr-Mills medical aid for the aged programs. Eligibility for Kerr-Mills benefits is based on need.

Mr. Johnson declares that private health insurance "usually costs more than the average retired couple can afford." But more than 60% of the entire population 65 and over is protected with health insurance.

Mr. Johnson calls upon all the states to provide "adequate programs of assistance" under the Kerr-Mills Law. Adequate programs under the Kerr-Mills Law provide hospitalization as well as physicians' services for elderly Americans who need help. But Mr. Johnson wants another program of hospitalization financed by increased social security taxes which would be available to everyone over 65, the wealthy included.

Mr. Johnson describes social security financed hospitalization as a program in which employees would contribute during their working years so they could receive benefits when they get old. But the U.S. Supreme Court has declared in major decisions that social security is a tax program in which people already retired receive support from taxes on the working people and their employers. In the case of Medicare, some 18 million elderly would receive more than 35 billion dollars in benefits during their lifetime at taxpayers expense and they would have paid nothing for these benefits.

Mr. Johnson calls for a payroll tax increase of one-half of one percent, with a quarter of one percent to be paid by the employee and an equal amount by the employer and the tax applied to a $400 increase in the taxable wage base. But a study by Robert J. Meyers, chief actuary of the Social Security Administration, has demonstrated that in a dynamic economy that tax increase would not be sufficient to finance this program for more than three years.

Mr. Johnson claims that the average worker would pay no more than a dollar a month to pay for this program of hospitalization for the elderly. But the average industrial wage in this country is more than $100 a week, and the tax increase proposed by Mr. Johnson would cost the $100 a week worker $27.50, not $12. Employers would pay an additional $27.50 for a total payroll tax increase of $55 on every $100 in wages. And that would be only the beginning.

Why should everyone over 65 get hospitalization at the expense of wage earners just because a few need help? Why should the workers of America be forced to pay higher taxes for hospitalization for everyone over 65, many of whom are wealthy and millions of whom have health insurance, just because they've had a birthday?

Edward R. Annis, M.D.
President, American
Medical Association

Editorial Notes . . .

Medical school applicants decreased gradually in numbers from 1956 (15,917) to 1961 (14,381). Then in 1962 the absolute number increased to 15,847, the first increase since 1956 and almost enough to equal 1956. During the same time the number of first year places to be filled also increased from 7,576 to 8,642. This makes the 1962 horde of applicants look a little smaller. Actually the number of applicants per place to be filled was highest in 1956 at 1.98. This ratio fell gradually and progressively to 1.69 in 1961. The 1962 ratio is only 1.83. On a ratio basis the class of applicants is not up to 1956, it is only up to 1959, and is still low.

The AMA has recommended that, if physical examinations are to be given by physicians to determine suitability for auto driving, the applicants to be examined be limited in number. The reasons are two: It would require a lot of medical manpower to give initial and periodic examinations detailed enough to mean anything to 91,000,000 drivers. And there is some evidence to indicate that impaired drivers are safer than unimpaired drivers due apparently to the fact that the impaired drivers are aware of their disabilities and utilize common sense and care, two commodities which some unimpaired drivers do not use. The AMA suggests examining only—when a license applicant displays an obviously impaired physical function; or when a driver has been involved in multiple accidents within a short calendar period; or when a driver must be placed in the "assigned risk" pool for insurance underwriting because of refusal by various commercial insurance carriers to assume the risk; or when a driver voluntarily suggests that he "blacked out" or that medical problems contributed to an accident. All of which brings to mind the old rule that mental and emotional troubles, not physical troubles, are the basic cause of auto accidents.

Dr. Alton Ochsner, who has been impressed longer than most of us with the danger of cigarette smoking, summarized the chilling statistics in a recent issue of *The New Physician.* He notes that "a man 50 years of age who has never smoked has an eight-year longer life expectancy than a man the same age who has smoked a package of cigarettes a day since he was 21." Also "the death rate from coronary heart disease is 115% greater among cigarette smokers than among non-smokers, and the death rate from cancer of the lung is 800% higher among cigarette smokers than non-smokers." He thinks that life insurance companies should give non-smokers preferential rates. In justifying the reliability of statistical evidence, he reiterates the

statement that a bridge which had been indicted by the same kind of evidence we have against cigarettes would have been closed several years ago.

Hyperbaric oxygen will be used for treatment and research in an entirely new addition to the Lutheran General Hospital at Park Ridge, Illinois. The million-dollar setup contains three interlocking pressure chambers, one with six beds, one with two operating tables and a special high-pressure chamber for decompression and special research. The Hartford Foundation contributed more than half the cost. The treatment chambers are maintained at two or three times normal air pressure. Oxygen given a patient by mask in this environment is circulated in the blood in a concentration 15 times normal. Patients with cyanosis, carbon monoxide poisoning, shock, severe heart attack or stroke whose oxygenation cannot be supported by ordinary means, are candidates for hyperbaric administration. In addition there is evidence that patients with anaerobic infections are benefited.

VA hospitals have progressed through an orderly and well received series of policies in relation to free cigarettes. For many years the distribution of free cigarettes has been dependent on the medical judgment of individual hospital directors. A number of hospitals have discontinued free cigarettes for as long as five years; others halted distribution after the most recent report by the Surgeon General. The VA, on February 5, issued an order prohibiting distribution of free cigarettes and other tobacco products in all of its 168 hospitals and 18 domiciliaries. An educational campaign will be conducted with patients and employees in an effort to discourage smoking. All bans by individual hospitals prior to the recent general order were well received both by patients and by the service organizations distributing the cigarettes.

Wyeth Laboratories, the Pharmaceutical Manufacturers Association, the Catholic Medical Mission Board and the Agency for International Development cooperated recently to supply 100,000 doses of typhoid vaccine for use by Public Health technicians in a province of Brazil which has suffered a 30,000 square mile flood. Brazilian officials requested the vaccine when sanitary conditions worsened. Wyeth donated the $14,000 order and dispatched it by air within 24 hours. This kind of news should be presented to the Senate sub-committee in charge of pharmaceutical investigations.

The pharmaceutical industry introduced only 576 new products in 1963, a 22% drop from 1962. New products vary from year to year naturally, with some other recent years showing a decline, but 1963 was unique in the large number of companies, many of them national in scope, who did not introduce a single new product. The differential between 1962 and 1963 would have been even greater if it had not been for the fact that 1963 saw a proportionately large number of new products in the vitamin, fluoride, cough remedy and skin product categories.

A by-lined news story in *The Observer* (London) recently told of the emigration of a research team from Birmingham University to the United States. Professor Ian Bush, physiologist, and four of his associates in research, all Ph.D.'s, have resigned and will soon form a research team at the Worcester Foundation, Worcester, Massachusetts. Dr. Bush's dissatisfaction and move is said to be due to the inadequacy of funds available for universities in England in general and medical schools in particular. At that, Birmingham University is reported as receiving a lion's share of research funds. The inference is that none of the researchers are getting enough.

There is a supposition that rear engine autos are more apt to catch fire in an accident since the gas tank is in front and front-end collisions are the most common. Not so, says Automotive Crash Injury Research. Both front engine and rear engine cars catch fire in the same proportion—slightly less than one-half of one percent. ◄

President's Page

Dr. Russell V. Lee, writing in a recent medical publication, stated "Alternatives to marriage must be found because monogamous marriage is a bizarre and unnatural state for the normal husband." He reasoned this on the very precarious assumption that "it is too much to expect a normal husband to be sexually faithful to one wife . . . in a state of nature, the normal buck, bull, stallion or primate collects, dominates and impregnates as many females as possible."



On first reading, this has a rather humorous connotation, but seriously considered, it reflects an unfavorable image concerning modern marriage by the physician. I am sure that the modern doctor does not have this attitude toward marriage. While emotionally the male may have extreme urges and desires, his reasoning control prohibits this in the emotionally mature individual. If he cannot, then perhaps Dr. Lee's comparison to lower animals is justified. I feel man is farther along than the buck, stallion or bull.

* * *

A new piece of legislation has been introduced in Congress to replace the Hill-Burton Act which expires June 30, 1964. It is the Hill-Harris Hospital and Medical Facilities Amendments—H-R 10041 introduced on Feb. 20, 1964. It establishes a five-year program to provide matching funds for public or non-profit, long-term facilities, diagnostic and treatment centers and rehabilitation facilities. The bill would also authorize grants for the construction or modernization of public health centers and public or non-profit hospitals. A loan program in the bill duplicates many of the provisions of the grant program including the requirement that projects applying for a loan would have to meet the same criteria as those applying for a grant.

The bill contains a separate program of mortgage insurance for the construction and modernization of the health facilities mentioned above, plus proprietary nursing homes. Mortgage insurance *for proprietary nursing homes* is presently provided under the F.H.A. The bill would transfer this authority to the Surgeon General.

As in the present act, the bill calls for the creation of a state plan in order to participate in the program and would require that applications for grants would have to be submitted through a state agency. Finally, the measure authorizes grants to the states to assist them in area-wide planning of health and related facilities. A companion bill S-2531 is in the Senate, (Hill).

The Council on Legislative Activities of the AMA recommended to the board of trustees the following: that the Harris bill be supported for three years with certain exceptions and additions:

(1) That two physicians be appointed to the Federal Hospital Council selected from a panel submitted by the AMA,

(2) That emphasis continue to repose on state administration of the program,

(3) That the term "public health centers" as facilities eligible to participate in the program be clarified so that said facilities be those which are *operated by an official Public Health Department,*

(4) That diagnostic and treatment centers be dropped as facilities eligible to participate in the program,

(5) That included in our support of the modernization provisions be the "Hill Bill" philosophy which encourages the use of funds for modernization from the outset,

(6) That we support mortgage insurance for the construction of hospitals and nursing homes (proprietary and non-proprietary) under F.H.A. (It is intended here that the F.H.A. program be extended to include the public and not-for-profit hospitals

and other facilities rather than restricting from F.H.A. coverage of proprietary nursing homes),

(7) Include language that would clearly express the congressional intent that the acceptance of Hill-Burton funds by a private facility does not make it a public institution. (A recent court action in North Carolina ruled that acceptance of Federal tax dollars would automatically make a private institution a public one),

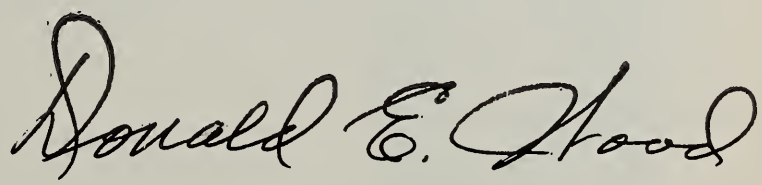
(8) That rehabilitation services at the state level be encouraged and

(9) That with respect to regulations that may be promulgated on "area planning," the state planning agency, where applicable, consult with the local medical society for its assistance in determining the need for the facility.

These recommendations were accepted by the board and testimony has already been given.

This legislation can have far-reaching effects and I feel each doctor should be aware of the provisions.

I note in one of the Indianapolis papers that Senator Hartke voted against his own bill to give tax relief to parents who have children in college. His bill was defeated 48 to 45. Senator Bayh also negated. Rather strange reaction for the gentleman from Evansville, don't you think? Both of these men endorse King-Anderson. Hartke is running for re-election.



The Woman's Auxiliary

REPORTS TO ISMA

My last report to you as president of your auxiliary is written with mingled feelings.

I feel justly proud of our accomplishments in the program of health careers; with the thousands of dollars given for scholarships and hundreds of hours spent in planning Health Career Days and Future Nurses Clubs; in our AMA-ERF program with over $12,000 contributed to date; in our mental health program with increasing number of our members becoming interested in this health problem. Our activities in the field of legislation have been manifold. Following the February 2nd legislation meeting in Indianapolis, we received reports of thousands of letters and telegrams being sent to the Congressmen. This is proof that we do CARE.



Our efforts in setting up joint meetings on the county level to view the "Barnstormer," AMPAC's political education film, have not resulted in the acceptance we anticipated. Letters were sent to each of the 58 county auxiliary presidents, asking them to contact the president of their county medical society for the purpose of allotting a time to show the film to the members of both the society and auxiliary. So far, five societies and auxiliaries have viewed this film with three scheduled for the near future. It is our hope that *all* members will avail themselves of the privilege of seeing this film. Please doctor, make a date with your auxiliary to see this political education film.

I have enjoyed serving as president of your auxiliary. The cooperation and support of the Executive Committee of the ISMA is deeply appreciated. A THANK YOU to Mr. James Waggener, the office personnel and *The Journal* staff for their help and guidance throughout the year.

Zelda K. Sullivan

in virtually all diarrheas...prompt symptomatic control

LOMOTIL®

TABLETS / LIQUID—Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride . . . 2.5 mg.
(Warning: May be habit forming)
atropine sulfate 0.025 mg.



Gastroenteritis | Functional diarrhea | Drug-induced diarrhea | Postsurgical diarrhea

Lomotil controls the basic physiologic dysfunction in diarrhea—excessive propulsive motility. Pharmacologic evidence indicates that it does so by directly inhibiting propulsive movements of the intestines. This direct, well-localized activity controls diarrheas of widely varied origin and does so promptly, conveniently and economically.

The relatively few conditions in which Lomotil has given less than satisfactory control have been, for the most part, those such as severe ulcerative colitis in which too little anatomic or functional capacity of the intestines remains for the motility-lowering action of Lomotil to have effect.

It should be noted, however, that Lomotil has proved highly useful in mild to moderate ulcerative colitis and in several other refractory forms of diarrhea.

The recommended initial adult dosage is two tablets (2.5 mg. each) three or four times daily, reduced to meet the requirements of each patient as soon as the diarrhea is controlled. Maintenance dosage may be as low as two tablets daily. *Children's* daily dosage (in divided doses) varies from 3 mg. for a child of 3 to 6 months to 10 mg. for one 8 to 12 years of age. Lomotil is an exempt narcotic; its abuse liability is low and comparable to that of codeine. Recommended dosages should not be exceeded. Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. Lomotil is a brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of atropine is added to discourage deliberate overdosage.

Research in the Service of Medicine SEARLE

Indiana Physicians Join In Auto Crash Injury Research

PHYSICIANS in nine Indiana counties began participation in auto crash injury studies the first of this month in cooperation with Cornell University and the Indiana State Police.

The first such study to determine the correlation between automotive design and injuries was originated in 1950 by the Indiana State Police. Since then, through the cooperation of 26 other states in the interstate ACIR program sponsored by Cornell University, information obtained has provided the basis for the designing of passenger protection devices such as seat belts, improved door latches, energy-absorbing steering wheels, padding, etc., with which automobile manufacturers began equipping their cars beginning with the 1956 models. Now, one of the purposes of the program is to collect data for use in evaluating the effectiveness of the adopted safety devices as they are modified, as well as showing the need for additional protection.

The Cornell studies employ the epidemiologic approach and in Indiana, as in the past, the study involves the cooperation of the Indiana State Medical Association, the Indiana State Police, the Indiana State Board of Health and the Indiana Hospital Association.

Accident investigators and members of the medical profession are contributing valuable data from this "laboratory of the highways" to the ACIR project located at the Cornell Aeronautical Laboratory, Inc. of Cornell University, in Buffalo, New York, where a standard technic of evaluation and analysis is employed to identify the characteristics of the environment producing trauma. The Cornell ACIR studies are sponsored by the USPHS and by the Automobile Manufacturers Association.

Thus far, the Cornell studies have shown that these safety devices are effective in preventing or in reducing the severity of injury. In the injury studies conducted on crashes involving the newer cars, it has been found that the incidence of door-openings during accidents has been reduced by one-third. Door latches of a greatly improved design have been incorporated in the 1963 models of two of the major car manufacturers and it is expected that these modified components will further reduce the frequency of door-openings.

As a result of these design modifications, it has been found that the frequency of passenger ejection is down about 40%, and the serious or fatal injuries have declined about 12%. Door latches haven't yet been made crash-proof, and if they could be so designed to control the ejection problem, the Cornell authorities are convinced that 5,500 additional lives could be saved each year.

When in use during an accident collision, it is reliably estimated that seat belts account for a 35% reduction in the risk of major or fatal injury.

The Indiana study is scheduled for a four-year period, but doctors will be asked to provide medical information only during the six-month period in which their county is represented in the sampling area. On an average there will be 12 counties included in any one period.

Counties included during the first sampling period are: St. Joseph, Marshall, Elkhart, Kosciusko, LaGrange, Noble, Whitley, Steuben and De Kalb.

When one or more occupants in a recent model passenger car (one of last four year models) have been injured, the state police officer assigned to investigate the accident will have two extra tasks to perform:

1. To take photographs of the damaged portions of the car and provide certain information with respect to the association of injury to car structure.

2. To deliver the Cornell medical report form, one for each injured person, to the

hospital emergency room or doctor's office where the injured are taken (or to the county coroner for passengers killed in the crash).

The physician will find that the form which he is asked to complete is a brief one, and since it is anticipated that reports will be sought on no more than four injured individuals per day in the average 12 county study area, the likelihood is small that an individual doctor will be excessively burdened.

During the first six-month period, Dr. Paul H. Martin, Commissioner of Health, Elkhart County, will act as medical coordinator for the study. His office will receive the reports from the State Police and from the doctors (in most instances through the hospitals where the patient has been cared for) and will forward them through the State Board of Health in Indianapolis to Cornell.

Physicians are urgently requested to participate in this renewed effort, for it is aimed at attacking one of the nation's foremost problems. Unless the injuries of each person injured or killed in a qualified passenger car accident within the sampling area are carefully recorded, the effectiveness of the study and the value of the data that is produced will be seriously reduced. All data received by ACIR is treated as privileged communication. ◄

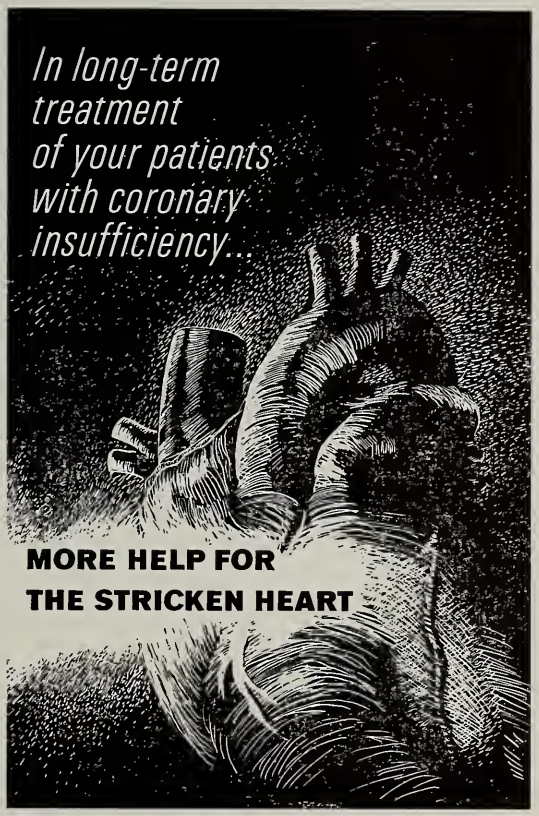
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Medical Society Representatives Discuss Legislative Issues

MEDICARE LEGISLATION in 1964 and what medical societies should be doing to protect the high standard of medical care in this country were the chief topics of discussion at a February 2nd meeting in the headquarters office of the Indiana State Medical Association.

Of the 129 in attendance, 88 were physicians, representing 44 county medical societies. In addition, representatives of county society auxiliaries and guests, representing organizations closely allied to the medical profession in its viewpoints on the King-Anderson Bill, were on hand to hear reports on fast-moving developments in Washington.

Dr. Eugene F. Senseny, Fort Wayne, chairman of the Commission on Legislation, sponsors of the all day session, presided over the meeting which was opened with remarks and discussion by Dr. Donald E. Wood, president of ISMA.

Others who participated were Mrs. Frank Gastineau, member of the board of the American Medical Political Action Committee; Mr. Richard Cardwell, general counsel, Hoosier State Press Association; Frank Woolley, field representative, AMA, and Dr. William Bannon, chairman of the I-Hope board.

The film, "The Gift of Health" was viewed and termed outstandingly appropriate in telling the factual side of the King-Anderson Bill to local clubs and organizations. Already, a number of societies are scheduling the film for such showings.

Tape recordings were made of the proceedings and are available to societies and individual physicians on request.



ASSEMBLED REPRESENTATIVES attending the Conference take time out for a box lunch in the basement of the headquarters. The group was the largest served in the building to date.



AT THE SPEAKERS table during the February 2nd legislative conference are (left to right) Dr. Joe Black, president-elect, ISMA; Dr. Don E. Wood, president and Mr. Richard Cardwell, general counsel, Hoosier State Press Association.



SPEAKERS AT the head table also included Dr. Eugene F. Senseny, Fort Wayne, chairman of the Commission on Legislation, sponsoring group; Mr. Frank Woolley, field representative, AMA; Mrs. Frank Gastineau, AMPAC board member and Dr. William Bannon, chairman of the I-HOPE board.



SHOWN IN THE second row of this picture (fifth and sixth from the left) are officials of the state auxiliary, Mrs. John M. Sullivan, president, and Mrs. Jack Shields, president-elect.

Riley Memorial Association Offers Camp for Handicapped Children

THE COOPERATION of all Indiana physicians is requested in contacting children who would benefit from two weeks of fun and recreation this summer at Camp Riley, the Riley Memorial Association's camp for physically handicapped children in Bradford Woods, a 2300-acre tract of land just north of Martinsville on Road 67. Every physically handicapped child from age 8 through 15 is eligible, regardless of economic circumstances. Camperships are available for those children whose parents are not able to pay the $60.00 fee.

The parent or guardian is responsible for the child's transportation and inexpensive camp clothing. A list is sent upon acceptance —and clothing can even be purchased if the family is in dire circumstances and sizes are known. A deposit of $2.00 also is required to be used during camp for incidentals, such as tooth brush, shoe laces and laundry. If not entirely used, the fee is returned at the close of camp. Towels and linens are furnished.

An admissions committee, made up of physicians, nurses, therapists and medical social workers on the staff at Riley Hospital, passes on all applications. There is a fully equipped infirmary where a doctor and nurse are on duty around the clock, assisted by student nurses specializing in the care of handicapped children at Riley Hospital. Counselors are experienced, college-level young men and women interested in health, physical education and recreation. Mr. Robert J. Wade, Jr., director of the 1964 season at the camp, has an extensive background in camp work.

Camp Riley has all weather, modernized cottage-cabins with a central lodge and dining hall. In addition to a heated swimming pool, there is a 110-acre lake with a beach designed for the handicapped child, pontoon boat and aluminum row boats. Craft and nature study, hiking in the densely wooded area, outdoor cookery and the other experiences a normal child enjoys at camp are provided, under careful supervision, for the crippled child restricted by leg braces, crutches, heart defects, cerebral palsy, blindness or other handicaps.

The camps begin on Sunday and parents are asked to pick up their child on Friday, 12 days later. The dates for the 1964 camps are June 21 to July 3, July 5 to July 17 and July 19 to July 31.

The Riley Memorial Association is most anxious to inform the parents of every handicapped child in the state of Indiana of this opportunity. Applications, which are to be filled out by the parents or guardian as well as the family physician, may be obtained from the Riley Memorial Association office at 129 E. Market St., Indianapolis 4, or by calling ME. 4-4474. ◄

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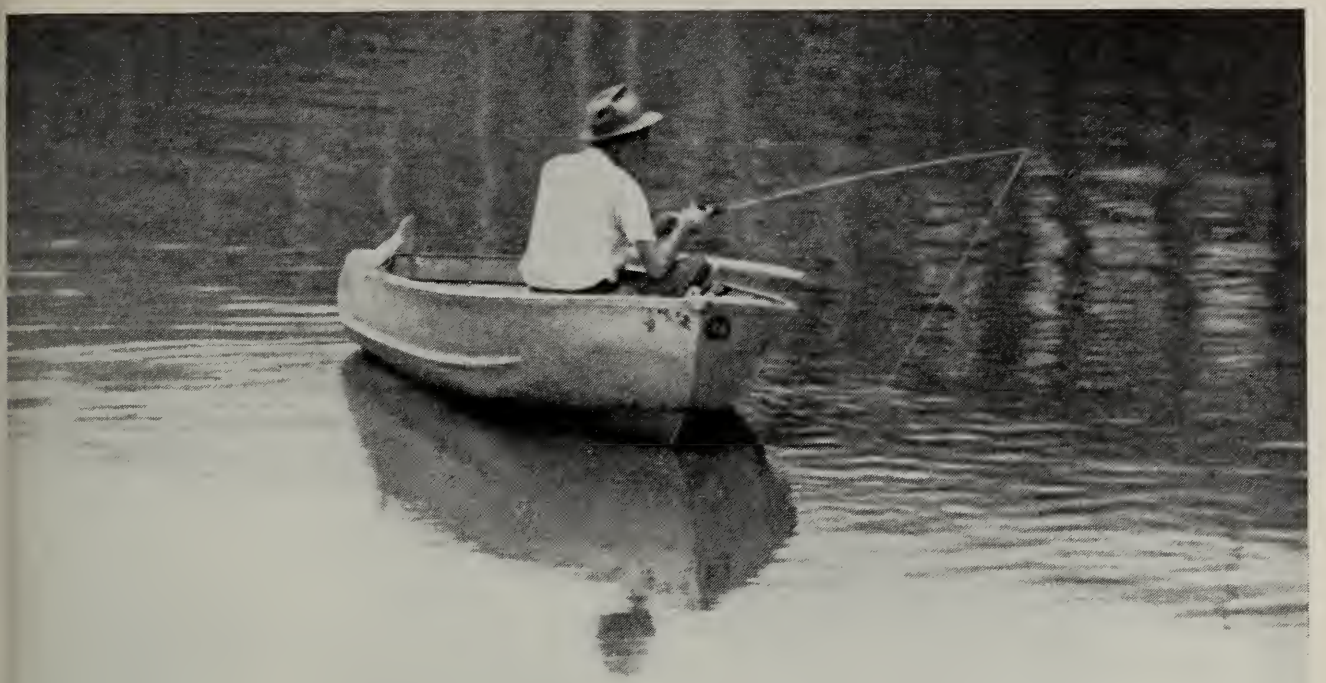
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The discharged mental patient . . . and Thorazine®

brand of chlorpromazine

"The average practitioner is quite capable of handling the vast majority of ex-institutionalized patients by regulation of medication, reassurance, manipulation of the environment where necessary, and . . . other technics." Kline, N.S.: Postgrad. Med. 27:620 (May) 1960.

The family physician must often assume responsibility for the discharged mental patient. Thorazine (chlorpromazine, SK&F) can be a valuable adjunct to the continuing care of this patient, because it helps prevent relapses by insulating him from the impact of stressful experiences. For successful rehabilitation and prevention of rehospitalization, however, the former mental patient—and often his family—also needs the guidance and counsel of his physician.

Many physicians are surprised by the high doses of Thorazine (chlorpromazine, SK&F) used in patients released to their care from mental hospitals. This surprise may be expressed by a drastic reduction in dosage "to play it safe"—with serious consequences for the patient.

The successful maintenance of former mental patients requires adequate, often "high" dosage, and often for prolonged periods of time. Fortunately, these dosages do not mean greater risks for the patient. On the contrary, there is much less risk of serious side effects once a patient has become gradually accustomed to Thorazine (chlorpromazine, SK&F)—*regardless of dosage*—over a period of a few months. Continuing therapy is almost always well tolerated, and is essential to most patients' continued well-being.

Brief Summary: Thorazine (chlorpromazine, SK&F) has been successfully used for 10 years in the treatment of mental and emotional disturbances, and has proven highly effective in the maintenance therapy of former hospitalized mental patients. *Principal side effects:* The most frequently encountered side effect is transitory drowsiness. Other occasional side effects include: dry mouth, nasal congestion, constipation, miosis, dermatological reactions, photosensitivity, jaundice, hypotension, increased appetite and weight; very rarely, mydriasis, agranulocytosis, extrapyramidal symptoms. *Contraindications:* Comatose states or in the presence of excessive amounts of C.N.S. depressants.

For complete prescribing information, please see *PDR* or available literature.

SK&F *Smith Kline & French Laboratories*

Congressional Views on Fedicare

February 15, 1964

Don E. Wood, M.D., President
Indiana Medical Association
3935 North Meridian Street
Indianapolis, Indiana

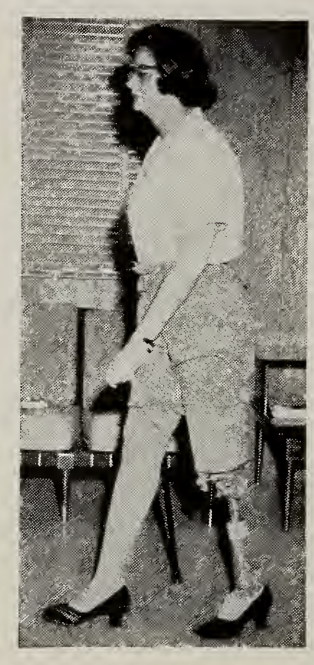
Dear Don:

Thank you for your letter expressing your views, and presumably those of the Indiana State Medical Association concerning the King-Anderson Bill. While I appreciate the fact that there is room for difference of opinion, I expect to support this legislation inasmuch as I am a co-sponsor of the bill.

It is always good to hear from you, Don, and good to know we can differ and still be friends.

Sincerely,
Vance Hartke
United States Senator

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Two important factors affecting the success of an amputee with a prosthesis are the fit of the socket on his stump, and the alignment of the prosthesis. With the Adjustable Leg the trained Hanger Prosthetist is able to achieve the best possible fit and alignment, which he can duplicate in the finished prosthesis.

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February 17, 1964

Dear Dr. Wood:

Thank you for your recent letter of the 11th. It was good of you to write and set forth your views on the proposed King-Anderson Bill.

As you know the open hearings (by the Ways and Means Committee) have been concluded. The reports that I have had indicate the committee will go into Executive Session on this bill sometime in March.

Whether the Committee will report the bill or not is not certain. Of course I think the Republicans pretty well have their Members lined up, but it is the Democrats that we have to worry about. In any event I will most assuredly do what I can to prevent this measure from being voted out. Thank you for contacting me.

Very truly yours,
Ralph Harvey
10th District

February 18, 1964

Dear Don:

Your letters were on my desk when I returned today from a series of Lincoln Day meetings in Indiana and one in Florida last night.

I appreciate having the information and the comments expressed in your letters, but as you know, I have not been convinced that the Administration's proposal to place the medical care for the aged program under the Social Security Administration is the answer to the problem. Certainly I think the Kerr-Mills program ought to be given a fair chance.

Up to this time, there is no indication that proponents of the legislation have been able to line up enough votes to get it out of the Ways and Means Committee.

Best regards.

Sincerely,
Charles A. Halleck
Second District

February 20, 1964

Dear Don:

Your letter of the 14th has reached my desk, and I appreciate this additional word concerning medicare legislation.

Of course, the implementation of Kerr-Mills legislation in Indiana will greatly reduce the need for broad medicare legislation and will improve our position considerably. I admit that we might be in better position had Kerr-Mills had an opportunity to demonstrate its advantages before the big push on medicare.

Best wishes.

Sincerely,
Richard L. Roudebush
Sixth District

February 21, 1964

Dear Don:

Many thanks for your recent letter telling me that you do not favor the Presidents' plan for financing medical care for the aged through Social Security.

In Indiana there are more than 457,000 citizens over 65 years of age. They go to the hospital twice as often and stay twice as long as their younger neighbors. Less than half of them have any hospitalization. Half of them have an average annual income of less than $1200. I am concerned about the welfare of these citizens of our state. A sensible plan for hospital and nursing home benefits should be provided.

Eligibility rules for benefits under the Kerr-Mills program are so strict that many believe the program is inadequate. But if Kerr-Mills is not a solution, neither is private insurance. The fact is that many senior citizens cannot afford such insurance at all, and of those that can afford it, not all can get it. Furthermore, private insurance can be cancelled, sometimes when it is needed most.

The Social Security program has been so successful in providing for the normal retirement needs of our senior citizens that it appears to be the best way of financing their hospital needs. The compelling point in favor of the Social Security approach is that it enables each citizen to save throughout his working years for his retirement without depending upon relief or governmental handouts which are paid for by everyone's taxes.

I appreciate your views on this subject and welcome your opinions on other matters.

Sincerely,
Birch Bayh
United States Senator

February 26, 1964

Dear Don,

Thanks for your very excellent letter of February 11, 1964 on the King-Anderson bill.

I think you know how I stand, without a question, on this one. I appreciate the figures included in your letter as they are quite a potent argument against the bill.

I am forwarding *The Indianapolis News* article you enclosed on the Supreme Court's overruling of Governor Welsh's veto of Kerr-Mills to Congressman Wilbur Mills.

Thanks for your valuable assistance.

Sincerely,
Donald C. Bruce, M. C.
Eleventh District ◄



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THE ARTHRITICS WHO COULD NOT TAKE STEROIDS

The bane of the steroids, new and old, has beer certain undesirable metabolic effects — includin and water retention, edema, overstimulation o appetite, excessive weight gain, mood swin seemed to be firmly linked to the primary inflammatory action. For arthritics already overwe or with cardiovascular disease complicated by ed or those who were tense and anxious, steroid ment could aggravate their problems. But wit advent of ARISTOCORT® Triamcinolone, ma these arthritics became "steroid-treatable." The son: Not only did *this* steroid provide gratifying of inflammation and pain, but it did so *withou* penalty of overstimulation of the appetite, exce weight gain, salt and water retention, edema, undesirable euphoria. Six years of widespread us confirmed these benefits for other arthritics as w those formerly untreatable.



e *Effects:* Since it may, under some circumstances, duce many of the unwanted effects common to all isone-like drugs, discrimination should always be rcised in administering ARISTOCORT® Triamcino-e. Any of the Cushingoid effects are possible, as are oura, G.I. ulceration, increased intracranial pres-e and subcapsular cataract. Corticosteroids gen-ly may mask outward signs of bacterial or viral ctions. Catabolic effects to watch for include scle weakness and osteoporosis. Weight loss may ur early in treatment but is usually self-limiting. *traindications:* While the only absolute contra-ications are tuberculosis, herpes simplex and ken pox, there are some relative contraindications otic ulcer, acute glomerulonephritis, myasthenia gravis, osteoporosis, fresh intestinal anastomoses, diverticulitis, thrombophlebitis, psychic disturbance, pregnancy, infection) to weigh against expected benefits.

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Gleaned from the British Medical Journal

JACK W. HICKMAN, M.D.
Indianapolis

This entire issue of *The British Medical Journal* supports the comment made by Dr. William Bean a few years ago that in the year 2060 we will look back on the 1960's as the time in which physicians formed committees to deal with the problem of medical education. Included in the issue are articles by Loeb[1] which deals with undergraduate medical education and Swift[2] dealing with postgraduate preparation for general practice. Loeb expresses the feeling that the introduction of more basic science into medical school curricula is a fine step; however, he warns that we must not place acceptance and success in medical school by depending upon one's research abilities. He is cognizant of the fact that research work has at times gained the upper hand in medical schools and that those participating exclusively in clinical activities tend to become "second-class citizens." He makes a further plea for the humanistic qualities in the practice of medicine and hopes for the inculcation of these admirable traits into the medical student. It is apparent that Swift is aware of the emphasis on specialization that is now present in his country as well as in the United States, for he stresses the importance of continuing education after medical school and internship. He bewails the lack of general practitioners in any active roles in medical education and the fact that students are not exposed to general practitioners during their clinical years. None of these complaints are new, of course, and it is particularly interesting to see that the problems are just as acute in the British Isles as they are in this country.

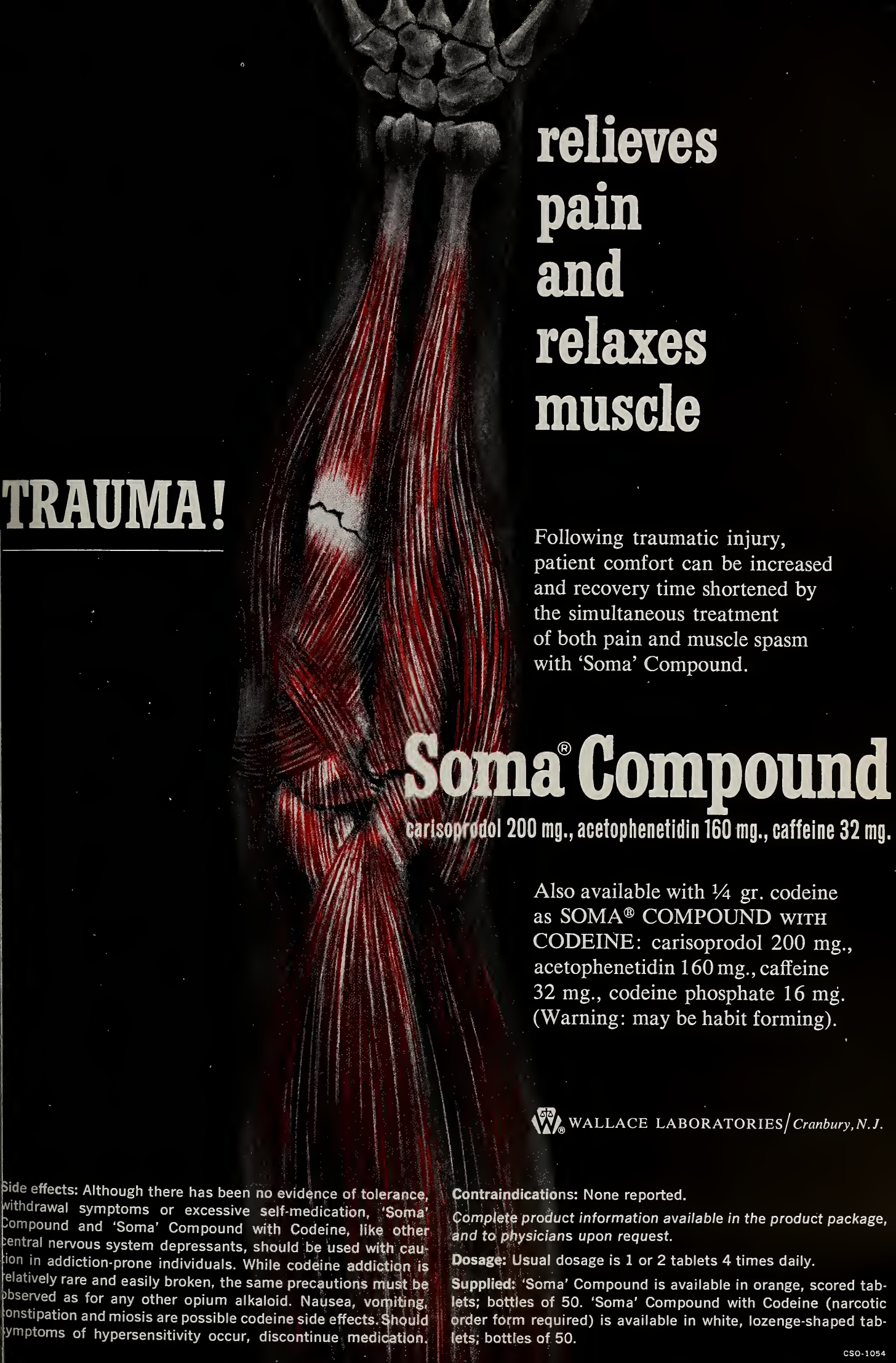
* * *

A study that will be quoted far and wide by those physicians in this country who are strongly against any further entrance by the federal government into the health field is presented by Craddock.[3] The author sent out questionnaires to a random sample of 100 members of the College of General Practitioners who had been qualified for from 10 to 20 years. The major purpose was to ascertain the satisfaction of these physicians with their lot in life and with their practice of medicine under the present National Health Service. Only slightly over 25% of the doctors surveyed appeared to be quite satisfied with general practice and would choose this field again if they were starting over. Furthermore, nearly another quarter stated that they did not enjoy their work. The main reason for dissatisfaction appeared to be the amount and distribution of payment for their services. Other complaints were lack of adequate ancillary help, virtually no contact with hospitalized patients and the relative lack of freedom. It would be interesting, of course, to compare a sample survey in the United States; and one would hope that a higher percentage of physicians are statisfied with their profession in this country.

* * *

Another aspect of the puzzling post-cardiotomy syndrome is presented by Robinson and Brigden.[4] This syndrome, otherwise known as Dressler's syndrome, has not been reported very frequently in Great Britain. The present study included the measurement of heart antibodies using the tanned-red-cell agglutination test in patients following mitral valve surgery as compared with a control series. All tests were negative in the controls and preoperatively in the 36 patients who had heart operations. In six cases postoperatively the test became positive, and five of these six patients were suffering clinically from the post-cardiotomy syndrome. A full discussion of the significance of these findings

Continued



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WALLACE LABORATORIES / *Cranbury, N.J.*

Side effects: Although there has been no evidence of tolerance, withdrawal symptoms or excessive self-medication, 'Soma' Compound and 'Soma' Compound with Codeine, like other central nervous system depressants, should be used with caution in addiction-prone individuals. While codeine addiction is relatively rare and easily broken, the same precautions must be observed as for any other opium alkaloid. Nausea, vomiting, constipation and miosis are possible codeine side effects. Should symptoms of hypersensitivity occur, discontinue medication.

Contraindications: None reported.

Complete product information available in the product package, and to physicians upon request.

Dosage: Usual dosage is 1 or 2 tablets 4 times daily.

Supplied: 'Soma' Compound is available in orange, scored tablets; bottles of 50. 'Soma' Compound with Codeine (narcotic order form required) is available in white, lozenge-shaped tablets; bottles of 50.

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follows in the article, and it is concluded by the authors that a circulating substance responsible for the positive test is not a product of the post-cardiotomy syndrome but is closely related to its pathogenesis. Although this is a preliminary report, it is felt that this opens up a whole new field in the pathogenesis of this syndrome.

* * *

A paper which reports the measurement of serum cholesterol levels in 20 male patients following myocardial infarction is presented by Watson et al.[5] A fall in the serum cholesterol occurs rapidly after a myocardial infarction, reaching its lowest level at about the sixth to ninth day and then rising slowly again to about the 22nd day when the level reaches the pre-infarction level. A fine discussion is included in the paper which offers speculation about the importance of this finding and the various mechanisms which might be causative. The one practical point from this investigation is that when hypo-cholesterolemic therapy is contemplated for patients who have suffered a myocardial infarction, control levels of the serum cholesterol cannot accurately be established until four to eight weeks after the acute event has occurred. The authors do offer the additional speculation that the degree of fall in serum cholesterol may be roughly correlated with the severity of myocardial damage that has occurred.

* * *

The combination of methyldopa and hydrochlorothiazide as compared with reserpine and hydrochlorothiazide in the treatment of hypertension is reported by Agnew et al.[6] Although this relatively small series of 18 patients was treated with both groups of drugs and also with a placebo control period, it was found that both drug combinations satisfactorily reduced blood pressure in roughly the same magnitude of degrees. The average blood pressure falls were in the range of 40/20 millimeters of mercury. Side effects were frequent in both treatment groups; and as far as symptomatic evaluation of the patients, all patients said that they felt better on the placebo. Although the mechanism of action of the methyldopa is very intriguing at first glance, it appears as if it is not going to add remarkably to our agents available for treatment of hypertension. The authors conclude with the truism that neither treatment schedule is ideal for moderate hypertension.

* * *

Macfarlane[7] writes a fascinating letter to the editor that will not cause any of us to lose sleep but gives us something to ponder. The correspondent went to the trouble of investigating the illegitimacy rate in his relatively closed community in England and correlated it with the instigation of coeducation in the school system which previously had been segregated as to sex. The striking thing is that the illegitimacy rate has doubled since 1959 when the change in the school policy occurred. Dr. Macfarlane admitted that these figures were obtained from a small sample and that they do not carry any statistical weight. However, he was fast to add that he would appreciate correspondence from any other physicians who have noted similar circumstances in their communities. He does not draw any conclusions in his letter, nor will this reviewer.

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Art, Hobby Show Planned For ISMA Indianapolis Meeting

Space will be provided at the 1964 annual meeting of the Indiana State Medical Association, Oct. 13-15 at Indianapolis, for a Physicians Art and Hobby Show.

Members of ISMA interested in exhibiting pieces and requiring any information regarding this can contact any one of the following:

Dr. Philip T. Holland
108 W. 7th Street
Bloomington

Dr. Charles P. Schneider
2211 W. Franklin St.
Evansville 12

Dr. Truman E. Caylor
303 S. Main St.
Bluffton

Dr. Frank H. Coble
51 S. Eighth Street
Richmond

Dr. Lall G. Montgomery
Ball Memorial Hospital
Muncie

ISMA Headquarters
3935 N. Meridian
Indianapolis 8

It will be the responsibility of each physician to see that his work gets to the exhibition at the Murat Temple. Final arrangements will be taken care of by Dr. Holland and his committee.

The ISMA will provide suitable display facilities, but each physician is responsible for transportation costs and any other such expense involved in entering his exhibit.

Application for Space in Art and Hobby Show Exhibit

Mail to:

Dr. Philip T. Holland
108 W. 7th Street
Bloomington, Indiana

Name_____

Address_____ City_____

Type and number of pieces to be displayed: Photography_____

Sculpture_____

Crafts_____

Painting_____

Other_____

Estimated amount of space required—lineal or square feet_____

Other information_____

Medicine At Law

DECISIONS AND OPINIONS

Highlights of recent court actions pertaining to health and medicine from *The Citation* prepared by the Law Division of AMA.

Surgeon not Liable for Unsuccessful Ear Operation—The fact that an ear operation did not improve a patient's hearing did not prove that the surgeon performing the operation was negligent. Affirming a directed verdict for the physician, an appellate court ruled that mere difference in views between surgeons as to operating technics or as to medical judgment exercised is insufficient to show malpractice, where the differing technics are all acceptable and customary methods of performing the surgery.

The patient, suffering from otosclerosis in both ears, underwent a stapes mobilization operation on his right ear. When the surgeon was unable to mobilize the bones, he closed the incision, packed the ear, and informed the patient that the operation to improve his hearing had not been successful. Thereafter, the patient suffered a further loss of hearing in the right ear, which he contended was due to the surgeon's negligence, and which the surgeon contended was caused by the progression of otosclerosis.

The patient's contention that the surgeon had cut the auditory nerve in his right ear was refuted by the doctor who testified as the patient's expert witness. The doctor also testified that, for an unknown reason, it is common for hearing loss to follow an operation, possibly because some ears are very sensitive to trauma. Further testimony showed a difference in views between the doctors as to preferred technics and practices, but the procedures followed by both were acceptable and usual in the field.

Holding that the doctrine of res ipsa loquitur does not apply in malpractice actions, the court said that an unintended result does not raise an inference of negligence. There was no evidence, the court concluded, from which the jury could have found that the doctor was negligent.

Hayes v. Brown, 133 S.E. 2d 102 (Ga., Sept. 4, 1963).

Doctors Liable for Negligence in Mental Examination even Though not Liable for False Imprisonment for Resultant Commitment—It is provided by statute that a person may be immediately committed to a mental institution upon the submission to the county court of a certificate, signed by two doctors who have examined the allegedly mentally ill person, stating that the condition of the person examined is such as to require immediate treatment in a mental institution and setting forth the facts on which such conclusion is based.

Following her release from the mental institution to which she had been committed in accordance with this statutory procedure, a woman brought an action against the two doctors who had signed the certificate leading to her commitment, charging false imprisonment and negligence in the performance of their examination. The jury returned a verdict for the doctors on the charge of false imprisonment but a verdict against them on the charge that they were negligent in making their examination.

The doctors moved to set aside the verdict. They contended that no doctor-patient relation existed because, in making the examination they were acting as mental health officers under the statute and, consequently, they did not have the duty of making the examination with ordinary care. The court said that the doctors assumed

the duty of making the examination as medical experts, not as judicial officers, and were, therefore, not clothed with judicial immunity. Since they were acting as medical experts they owed the woman the duty of making the examination with ordinary care and are liable for their negligence in making the examination. The motion to set aside the verdict was accordingly denied.

Kleber v. Stevens, 241 N.Y.S. 2d 497 (N. Y., June 19, 1963).

Ban on Tattooing Except for Medical Reasons Held Unconstitutional—A New York City Board of Health regulation prohibiting tattooing except for medical reasons by doctors authorized to practice medicine or osteopathy was held unconstitutional. A ban on unsanitary and unsterile tattooing would be sufficient, the court said, to accomplish the regulation's purpose of protecting public health against contagion of serum hepatitis.

Expert witnesses testified that tattooing could be performed in a manner that presented no health problem with regard to serum hepatitis. A trained lay person, they said, could maintain sterile conditions in performing such work, and tattooing machines and equipment can be entirely sterilized.

The court pointed out that the restriction to tattooing "for medical purposes" would present a problem with respect to tattooing performed in conjunction with plastic surgery. Even doctors would be forbidden to tattoo an individual for ornamental purposes, despite the fact that many distinguished persons have had ornamental tattooing done.

The Board of Health contended that the ban was necessary because a previous regulation requiring sterile and sanitary conditions in tattooing establishments was ineffectual, since there had been an increase in the number of cases of serum hepatitis from unsterile tattooing. However, the court pointed out that the Board of Health had never attempted to enforce the previous regulation through criminal proceedings or civil penalties. Inadequate enforcement of the regulation, the court said, cannot justify prohibition of a lawful calling.

Continued



The argument that tattooing "serves no useful purpose" was not only insufficient to justify the ban but was also disproved by evidence that tattooing may serve both medical and ornamental purposes. An activity innocent in itself may not be validly prohibited merely because, under some conditions, it is a danger to public health.

Grossman v. Baumgartner, 242 N.Y.S. 2d 910 (N.Y., June 28, 1963).

Surgeon Exonerated in Death of Patient—In a suit against a surgeon and a hospital charging negligence which resulted in the death of a patient, a verdict in favor of the surgeon and the hospital was directed by the court. This action was taken after all the evidence against them had been presented.

Four hours after a hernia operation, the abdomen of the patient was found to be filled with blood. Further surgery disclosed a severed blood vessel without ligation. The patient recovered but died of a heart condition more than four years later. The surgeon was charged with negligence in failing to ligate the blood vessel. The hospital was charged with negligence in providing bad lighting in the operating room. In defense against these claims, it was argued that the ligature could have slipped off the blood vessel.

Scardina v. Colletti, Docket No. 59S-13620, Super. Ct., Cook Co. (Ill., Jan. 17, 1964).

Doctor's Silence in Face of Accusation of Malpractice not Admissible Evidence in Subsequent Malpractice Action—A verdict was returned in favor of the doctor in a malpractice action. The patient appealed on the ground that certain evidence had been improperly excluded. The Pennsylvania Supreme Court upheld the trial court's ruling and affirmed the judgment in the doctor's favor.

When the patient's condition worsened while she was being attended by the doctor, her husband removed her from his care and placed her under the care of several other doctors.

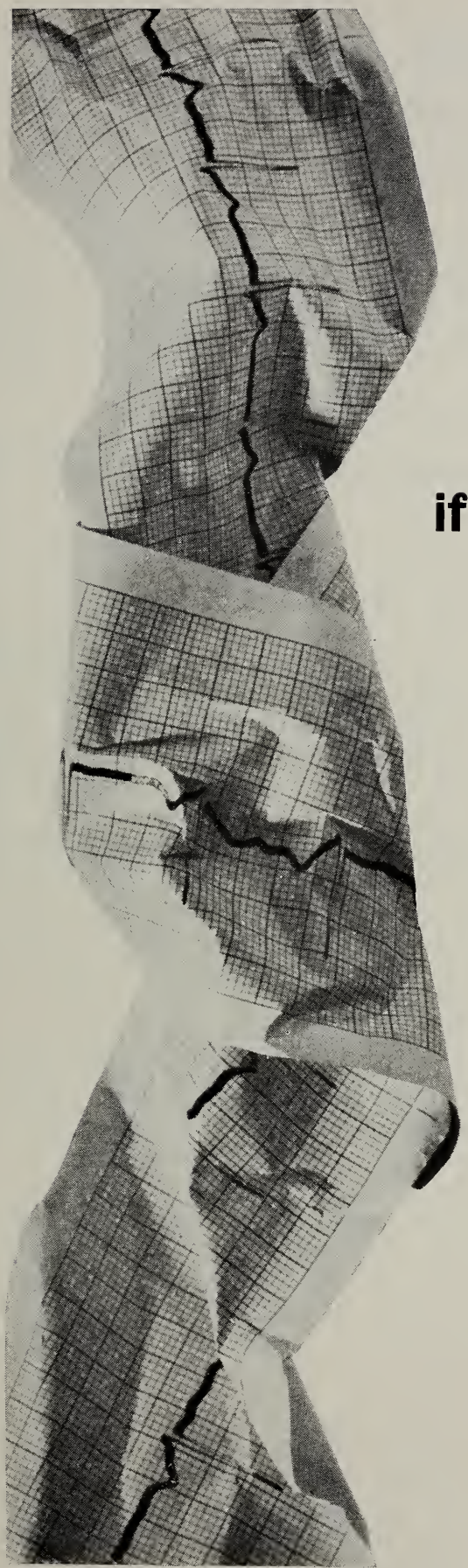
At the trial, the patient sought to introduce evidence with respect to a telephone call her husband made to the doctor a few days later. He told the doctor about the treatment his wife had been receiving the past few days. He also said he had been told by the doctors then attending his wife that her condition had been caused by the doctor's malpractice and that he, therefore, expected the doctor to assume all costs of his wife's illness. The doctor allegedly remained silent in the face of this accusation of malpractice. In offering this evidence, the patient was not attempting to prove the truth of the matter in the husband's statements, but was attempting to prove an admission by silence.

The court said this evidence was properly excluded. The rule as to admissions by silence is as follows:

> "The failure of a party to reply to a statement made in his presence or hearing is significant only where the nature of the statement, and the circumstances under which it was made, are such as render a reply natural and proper . . . On an accusation of negligence giving rise to a civil action, if one is restrained by fear or doubts as to his rights, or by the belief that his interests will be best promoted by his silence, then no inference of assent can be drawn from that silence. . . ."

The patient also offered in evidence two letters written by her husband to the doctor, setting forth in detail the later treatments she had undergone and the expenses he had incurred, and repeating his assertion that the doctor should assume all costs of his wife's illness, together with a $200 check sent the husband by the doctor two months after the second letter. The Supreme Court upheld the trial court's exclusion of these papers on the ground that they were self-serving declarations. The judgment for the doctor was accordingly affirmed.

Levin v. Van Horn, 194 A. 2d 419 (Pa., Oct. 10, 1963). ◄



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Blue Cross—Blue Shield Protection for Federal Employees: Supplemental Programs

(One of a series prepared by Blue Cross-Blue Shield)

Some 50,000 persons are protected by Indiana Blue Cross-Blue Shield programs for Federal employees and their dependents. The programs include the basic programs described in last month's article, plus supplemental programs that add to the basic programs in amount and kind. As in the case of the basic programs, these members have either the high level or low level supplemental program.

Supplemental benefits apply to services rendered in the home, physician's office, hospital or elsewhere. They may be used without the use of basic benefits, along with the use of basic benefits, and before or after the use of basic benefits. They are subject to deductible and coinsurance, as well as dollar maximums.

Between basic benefits and supplemental benefits there is a deductible to be paid by the Federal employee member. After this deductible is paid, supplemental benefits provide payment for the major portion of most covered expense over the deductible. The deductible is $100.00 under the high level supplemental program, and $150.00 under the low level program.

There is a separate deductible for each covered dependent of the member's family for each benefit period. However, under a family enrollment covering three or more members, only two deductibles have to be satisfied during any benefit period.

When a patient exhausts his basic benefits, he is entitled to supplemental benefits. Also, while a patient is receiving basic benefits, he is entitled to receive concurrently certain benefits that are provided only under supplemental benefits.

Supplemental benefits include the following physician's services covered under both the high level and low level programs:

Services of physicians, including specialists, in and out of a hospital, for surgery, in-hospital medical care, in-hospital consultations, office visits and home calls, administration of anesthesia, x-ray and diagnostic laboratory procedures, radiation treatment and blood transfusions. Supplemental benefits for reasonable and necessary expenses, are paid without regard to fee schedules.

After the deductible has been met by the member, coinsurance then provides for the following:

High level: Plan pays 80% of remainder of covered expenses up to a maximum of $30,000, and the member pays 20%.

Low level: Plan pays 75% of remainder of covered expense up to a maximum of $10,000, and the member pays 25%.

When the $30,000 or the $10,000 maximum benefit has been paid to an individual, benefits can be reinstated upon acceptable evidence of his insurability.

A benefit period begins on the first day that a charge is incurred for services or supplies covered by supplemental benefits. It ends 12 months after it began. There is a separate benefit period for each covered dependent of the member's family.

Supplemental benefits include special benefit provisions for diagnostic examinations not covered by the basic programs. To the extent that they are not covered by basic benefits, supplemental benefits of 80% (high level) or 75% (low level) will be paid for diagnostic examination charges in excess of $20.00 (high level) and $25.00 (low level) incurred during a single benefit period for the following services in a hospital, in a physician's office, or elsewhere:

- X-ray examinations
- Laboratory examinations (except allergy tests and surveys)
- Basal metabolism examinations
- Electrocardiograms
- Electroencephalograms
- Radioisotope examinations

To claim supplemental benefits, the federal employee member must file a completed major medical claim form, together with itemized bills and receipts connected with the claim. The physician does not complete a major medical claim form unless requested to do so by the member, who supplies the form.

The completed form, together with the attachments should be submitted to: Blue Shield, 110 N. Illinois St., Indianapolis, Indiana, 46209, Attn.: Federal Employees Supplemental Claims Department.

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The Journal Welcomes New ISMA Members

James A. Bone, M.D., *Psychiatry*, Meharry Medical College, 1919. (LaPorte)

Mac C. Roller, M.D., *General Practice*, Indiana University, 1960. (Hendricks)

James J. Wright, M.D., *General Practice*, Stritch School of Medicine, 1959. (Marion)

Gus W. Neece, M.D., *General Practice*, University of Illinois, 1933. (Delaware-Blackford)

William Shriber, M.D., *Ob-Gyn*, Ohio State University, 1957. (St. Joseph)

Thomas F. Keough, M.D., *Internal Medicine*, University of Chicago, 1959. (Kosciusko)

N. H. Ozalan, M.D., *General Practice*, University of Istanbul, Turkey, 1944. (Dubois)

Richard R. Slough, M.D., *General Practice*, Indiana University, 1962. (Noble)

J. E. Gahimer, M.D., *Internal Medicine*, Indiana University, 1957. (Madison)

C. R. Woodbury, M.D., *Orthopedic Surgery*, Indiana University, 1956. (Madison) ◄

SCIENTIFIC EXHIBIT APPLICATION FORM

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Indiana State Medical Association
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Please send me an application form for a Scientific Exhibit at the ISMA Annual Convention, October 13-15, 1964, Murat Temple, Indianapolis, Indiana.

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WANTED: Locations Physicians

GENERAL PRACTICE

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Robert C. Miller, 11211 Tecumseh, LaGrange, Ill.
William C. Parke, 926 Penrose, Detroit 3, Mich.
William S. Grabeel, P. O. Box 217, Pleasant Garden, N. C.
Robert L. Ilaria, 6317 Thumper St., Jacksonville 10, Fla.
David S. Kerwin, Jr., 1706 Barbara Way, Modesto, Calif.
Arnold W. Matera, 1607-A S. Pine, Blytheville AFB, Ark.

SPECIALISTS

Antonio M. Chiasson, 27151 Sidney Dr., Suite 41, Euclid 32, Ohio—*Anesthesiology—willing to do general practice*
James H. Epps, 2752 W. Boston, Apt. C-7, Detroit 6, Mich.—*Anesthesiology*
Pablo E. Gonzalez, 3401 Toledo Terrace, Apt. J, Hyattsville, Md.—*Anesthesiology*
Jerry W. Anderson, 1716 Glastonbury Rd., Ann Arbor, Mich.—*Internal Medicine—Hematology*
Keith D. Smith, 9239 Blue Grass Rd., Philadelphia, 14, Pa.—*Internal Medicine—Fertility—& Endocrinology*
Donald F. Nagler, 3185 Dwight, Ann Arbor, Mich.—*Internal Medicine*
James D. Wismar, 14508 Garfield Ave., Lakewood 7, Ohio—*Internal Medicine*
Ernest C. Mirich, 7336 Churchill, Detroit 6, Mich.—*Internal Medicine*
E. Stephen Kurtides, 1014 Main St., Evanston, Ill.—*Internal Medicine—Hematology*
Vincent Taormina, 1034 Marcy St., Iowa City, Iowa—*Neurology*
Mary Patricia Shanahan, 561 N. 64th St., Milwaukee, Wisc. 53213—*OB-GYN*
John W. Luttrull, APO 731, Seattle, Wash.—*OB-GYN*
Elias J. Umali, Chester Hospital, 9th and Barclay Sts., Chester, Pa.—*OB-GYN*
Antonio Hernandez, 16 East Mill St., Shelburn, Ind.—*OB-GYN*
James L. Stribling, 1300 W. Michigan St., Indianapolis, Ind.—*OB-GYN*
Maurice B. Schwartz, 5010 Castelar, Omaha 6, Neb.—*OB-GYN*
Herman D. Nienhuis, 2669 Capehart, Bunker Hill AFB, Peru, Ind.—*OB-GYN*
Regis L. Callaghan, 18072 Snow Rd., Dearborn 8, Mich.—*OB-GYN*
Edgar R. Cantwell, 3577 Moller Rd., Indianapolis 24, Ind.—*Ophthalmology*
George M. Hazel, Newington Hospital For Crippled Children, Newington, Conn.—*Orthopedic Surgery*
James M. Morse, 266 Castleman Rd., Rochester, New York—*Orthopedics*
Robert P. Balderson, 370 Millet Lane, Pittsburgh, Pa.—*Pathology*
Dalton L. Kinsella, Jr., 50 Hale St., West Springfield, Mass.—*Pathology*
Carter D. Brooks, 4905 Janet Dr., Corpus Christi, Texas 78411—*Pediatrics*
William W. Brauer, 112 Leblanc, Fort Bragg, N. C.—*Psychiatry*
Robert V. Wade, 5512 Warwick Rd., Cleveland, Ohio—*Radiology*
Eric T. Lincke, Station Hospital, NAS Whidbey, Oak Harbor, Wash.—*General Surgery*
William F. Briney, 820 Hannah St., Forest Park, Ill.—*General and Thoracic Surgery*
John A. Schadler, Box 550, Nome, Alaska—*General Surgery*
William T. Anderson, 1302 Louisville Highway, Goodlettsville, Tenn.—*General Surgery*
Hubert G. Buehler, 2467 Redondo Ave., Salt Lake City, Utah—*General, Vascular and Chest Surgery*
Andrew H. Biscan, 102 Regal Dr., De Kalb, Ill.—*General Surgery*
Kyung J. Ahn, 1900 East Main St., Danville, Ill.—*General and Thoracic Surgery*
Robert E. Knode, 407 Michigan National Bank Bldg., Battle Creek, Mich.—*General Surgery*
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William J. Potts, 844-B Birch Circle, Fort Devens, Ayer, Mass.—*General Surgery*
William M. Reid, 146 Deerfield Ave., Waterbury, Conn.—*General Surgery*
James J. Gibbons, 7746-B Olson Loop, Fort Meade, Md.—*General Surgery*
Kenneth R. Haslam, 422 W. Dempsey Rd., Oxnard, Calif.—*Aerospace, College Health, and Pharmaceutical*
Zol F. Muskovitch, Dept. of Pharmacology, University of Michigan, Ann Arbor, Mich.—*Pharmaceutical Industry or Chemical Industry*
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Type E Botulism Antitoxin

The Public Health Service is stockpiling antitoxin to be reserved for use against type E botulism. It will be stored at PHS Communicable Disease Center, Atlanta, Georgia, which will be on 24-hour call for emergency use.

The CDC emergency number is Area Code 404, telephone 634-2561.

ADDITIONAL LOCATIONS

COUNTY **TOWN**

Clinton—MULBERRY—population 1,000 with a surrounding population of 2,000. Located 10 miles from Lafayette, home of Purdue University, and two excellent, open staff hospitals. Ten miles from Frankfort, county seat, where the county hospital is located. Mulberry is located in a rich farming area. Home and office available. No physician in the community. Contact Mr. Eldon Skiles, Farmer's Bank; Rev. Russell Bussabarger or Mrs. Bert V. Livelsberger, all of Mulberry.

Decatur—WESTPORT—population 1,035—located 14 miles from Greensburg where hospital facilities are available. Office and residence available. Only physician in the community is past 80 years of age. Contact Mr. Richard A. Maddus, P. O. Box 177, Westport, for further information.

Dubois—FERDINAND—General practice in small community available. New clinic building fairly well equipped. Population approximately 2,000 with another 1,500 persons in small towns nearby. Hospital at Jasper, 12 miles away, and another at Huntingburg, 9 miles away. One hundred percent German-Catholic community. Contact H. G. Erhart, M.D., Ferdinand Clinic, Ferdinand, Ind., for more information.

Gibson—OWENSVILLE—population 1,100 with a large surrounding territory, mainly farming community. Twenty-five miles from Evansville where three hospitals are available and 15 miles from Princeton where a new 60-bed hospital is located. No physician in the community. Office available. Contact Marion E. Warpenburg, D.D.S., Owensville, for further details.

Howard—GREENTOWN—population 1,300. Located nine miles from Kokomo where hospital facilities are available. New office space located in new shopping center which will also include offices for a dentist. Community needs and can support another physician. Contact Mr. Richard Zirkle, 508 E. Main St., Greentown, for further details.

Porter—CHESTERTON—General practitioner wanted for partnership with Dr. John E. Read who has practiced in Chesterton for five years. Position available will be that of associate, on salary guaranteed at $1,000 per month and increases if warranted for one year, with partnership available thereafter. No investment necessary. A new $50,000 office building will be constructed this summer. Hospital located at Valparaiso, 12 miles away. Population 5,000 with a surrounding farm community totaling seven to 8,000 and growing due to the influx of new steel industry. Contact Dr. John Read, 114 S. Eleventh St., Chesterton, Ind., for details.

Posey—CYNTHIANA—population 600. Located 18 miles from Evansville where hospital facilities are available. Community without the services of a physician. For further information contact Rev. Edward B. Byrd, P.O. Box 116, or Miss Helen M. Martin, both of Cynthiana.

MT. VERNON—population 7,000, located close to Evansville. Doctor shortage has become acute. Posey County Medical Society and the Chamber of Commerce interested in securing physicians for the community. Contact Mrs. Bess L. Mangis, Executive Secretary, Mt. Vernon Chamber of Commerce.

Scott—SCOTTSBURG—population between 4,000-5,000. County seat town. New 30-bed hospital. Large surrounding territory without the services of a physician. County medical society interested in having general practitioners locate in Scottsburg. Contact James Sabens, M.D., 69 Wardell Street, Scottsburg, secretary of the Scott County Medical Society.

Sullivan—CARLISLE—population 755 with a township population of 1,425. Farming community. Located 10 miles from Sullivan and 20 miles from Vincennes where hospital facilities are available. One physician in the community who is limiting his practice. For further information contact A. G. Callahan, Superintendent of Schools and H. Glenn Berry, Bank Cashier, Carlisle.

Vanderburgh—DARMSTADT—Village Square Shopping Center located approximately 10 miles north of Evansville in small town of Darmstadt. Plans for a doctor's office under consideration. Growing community with approximately 1,500 homes and 6,000 persons in a four mile area. Contact Robert L. Willner, Village Shopping Center, R. R. 5, Box 242, Evansville, Ind.

Whitley—SOUTH WHITLEY—population 1,500. Located in the lake region of northern Indiana. Close to Fort Wayne. General practitioner needed in the town. Office available. Contact Glenn Watson, Secretary, South Whitley Chamber of Commerce, for details. ◄

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BONE AND JOINT CLUB
Date April 22
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INDIANA STATE SOCIETY OF ANESTHESIOLOGISTS
Date May 18
Place Athletic Club, Indianapolis

INDIANA SOCIETY OF INTERNAL MEDICINE
Date November
Place Indianapolis

INDIANA HOSPITAL ASSOCIATION
Date October 28-29
Place Indianapolis

INDIANA NEUROPSYCHIATRIC ASSOCIATION
Date Second Wednesday of every month, October through May
Place The Athenaeum, Indianapolis

INDIANA STATE MEDICAL ASSOCIATION CONVENTION
Date October 12-15
Place Murat Theater, Indianapolis

INDIANA ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY
Date May 6-7
Place Marott Hotel, Indianapolis

INDIANA ORTHOPAEDIC SOCIETY
Date May 22-23
Place South Bend

INDIANA ASSOCIATION OF PATHOLOGISTS
Annual Seminar
Date May 17
Place Veterans Administration Hospital, Indianapolis

INDIANA ROENTGEN SOCIETY
Date May 3
Place Marott Hotel, Indianapolis

INDIANA PUBLIC HEALTH ASSOCIATION
Date May 13-14
Place Severin Hotel, Indianapolis

NORTHERN INDIANA PSYCHIATRIC SOCIETY
Date Fourth Wednesday of every month, September through June
Place For location and program, inquire Beatty Memorial Hospital, Westville



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ABSTRACTS

BOOK REVIEWS

MAN AND HIS FUTURE

Ciba Foundation Symposium, edited by Gordon Wolstenholme. Little, Brown & Co., Boston, Mass., 1963. 408 pages. $6.00.

No less than 27 distinguished representatives of the scientific community gathered in Ciba Foundation's new home on Portland Place in London to hold a sort of house-warming party: an augury of many such meetings, we hope.

The discussions ranged from the highly technical to the generally philosophic. Dr. Hilary Koprowski fascinated me with a trenchant analysis of the "Future of Infectious and Malignant Diseases." Dr. Hermann J. Muller presented a most thought stimulating essay dealing with *eutelegenesis*, germinal choice (the word was new to me also). His point was the establishment of germ cell banks with detailed documentation of the donors' qualities

A. Szent-Györgyi dwelt on "The Promise of Medical Science"; Brock-Chisholm waxed eloquent on the "Future of the Mind"; Gregory Pincus spelled out the need for control of reproduction—and these are only a few examples of the fare being offered to the reader.

The printing and binding are good. All in all, this is an excellent volume to pick up and read, a chapter at a time, both for profit and enjoyment.

ARNOLD LIEBERMAN, M.D.
New York, N. Y.

PEDIATRIC CARDIOLOGY

Alexander S. Nadas, M.D. Second edition, W. B. Saunders Co., Philadelphia, Pa., 1963. 828 pages; 527 figures; appendix with 34 tables. $16.00.

It is seldom that a recent book acquires the stature of an established classic: Dr. Nadas has achieved this enviable distinction. Clearly and simply written, he draws the bold profiles of answers to questions plaguing the student, practitioner and specialist.

The format and excellent index permit ready access to the point being raised. Part one, "The Tools of Diagnosis", gives the reader an understanding of what is recent and pertinent in what to do about arriving at a diagnosis. Part two, "Acquired Heart Disease", is self-explanatory. The discussions on rheumatic fever, endocarditis, myocardial diseases, etc. are crisp, lucid and almost uniformly satisfying. Part three, "Congenital Heart Disease" is more of a summary than an extended discussion. Undoubtedly, Dr. Nadas will amplify, in future editions, this explosively expanding subject.

Surgery is becoming more and more an integral part of the therapeutic approach to cardiac disease, both congenital and acquired. One can also anticipate that the author will devote space to this aspect of cardiac pediatrics. All in all, this monograph is becoming a "must" for *everyone* having any interest whatever in the topic. Dr. Nadas is to be congratulated on a task superbly performed.

ARNOLD LIEBERMAN, M.D.
New York, N. Y.

SURGICAL PATHOLOGY

Lauren V. Ackerman M.D., C. V. Mosby, St. Louis, Mo. Third edition, 1964. 1244 pages, 1216 illustrations. $18.75.

This text has become a standard reference in surgical pathology since its first edition in 1953. Dr. Ackerman, the surgical pathologist, has collaborated with Dr. Butcher, the practicing surgeon, to write this excellent book.

The work, while not written as an encyclopedia of surgical pathological lesions, covers the vast majority of surgical conditions one encounters in practice. One of the outstanding features is the fine clinicopathological correlation found throughout the chapters.

Outlines of clinical symptoms, therapeutics, and prognosis based on gross and histological appearance of lesions are included in the clinicopathological correlation sections. The photographs are of good quality and abundant throughout the text. Electron microscopic photographs are included. The bibliographies are up-to-date and well chosen. The book is a practical and authorative aid to the pathologist, surgeon or other physician concerned with diagnosis or treatment of patients having surgical lesions.

JAMES J. SULLIVAN, M.D.
Indianapolis

Abstracts From Various Literature, Prepared by AMA

VINCRISTINE SULFATE IN THE TREATMENT OF LYMPHOMA AND LEUKEMIA

J. Martin (Brighton 1, England), N. Compston, *Lancet* 2:1080 (Nov. 23) 1963.

Nineteen patients with disseminated malignant lymphoma and leukemia were treated with vincristine sulfate, an alkaloid extracted from the periwinkle plant, Vinca rosea Linn. Partial or occasionally complete remission followed in all ten treated for lymphoma. Three patients with monocytic leukemia (Naegeli type) responded; one of three with chronic lymphatic leukemia responded; and two with chronic myeloid leukemia, who had relapsed on busulfan treatment, responded hematologically but died of infection. One patient with multiple myeloma did not respond. Toxic effects, particularly neurotoxic, were prominent but not permanent. Results indicated that further

trials with this drug, especially in the lymphomas, are justifiable.

HYPERBARIC OXYGEN IN THE RESUSCITATION OF THE NEWBORN

J. H. Hutchison (Glasgow, Scotland), M. M. Kerr, K. G. Williams, W. I. Hopkinson, *Lancet* 2:1019 (Nov. 16) 1963.

A trial of hyperbaric oxygen is described in which a small perspex chamber capable of compressing oxygen up to four atmospheres (absolute) (45 lbs. per sq. in.) was used in the treatment of severe asphyxia neonatorum. This form of therapy meets the urgent requirement of the apneic newborn infant by introducing oxygen into the circulating blood as quickly as possible. Immersion of the infant in pure oxygen at two to four atmospheres produces a gradient of 1,500 to 3,000 mm Hg between the environment and the infant's hypoxic tissue fluids. Sixty-five infants were placed in the chamber. Thirty-five (54%) recovered; 16 (25%) were successfully resuscitated but died later from various causes; 14 (21%) failed to resuscitate or died within six hours of birth. It is concluded that hyperbaric oxygen is an effective treatment for severe neonatal asphyxia.

CART FOR CARDIOPULMONARY RESUSCITATION

J. S. Israel (150 St. George St., Toronto), K. McCulla, A. B. Dobkin, *Canad. Med. Ass. J.* 89: 1284 (Dec. 21) 1963.

The authors have devised a cart for use during cardiopulmonary resuscitation. Its principal purpose is to bring all pieces of equipment and drugs essential for revival to the pulseless and apneic patient and avoid the unnecessary effort and confusion that often attends such an event. Photographs of the cart and lists of strategically placed contents are described. The authors feel that there will be an increase in the effectiveness of acute resuscitation attempts in hospitals, if such a cart is used regularly. They suggest that the cart be used after the necessary formal training and instruction in resuscitation procedures and after frequent reading of an appropriate instruction poster. The use of an adequate protocol to report all these events is also advocated.

MASSIVE HEMORRHAGE FROM DIVERTICULAR DISEASE OF THE COLON

W. S. Anderson (10004—105th St., Edmondton, Alberta) *Canad. J. Surg.* 7:21 (Jan.) 1964.

Cases of massive colonic hemorrhage from diverticular disease admitted to the Royal Alexandra and University of Alberta Hospitals during the last ten years have been studied. The cases constituted only seven percent of those admitted with symptomatic diverticular disease. Of the 17 cases, only two required emergency surgery and both survived. One patient, in whom diverticular disease was complicated by cardiovascular disease, died without surgery. The various methods of dealing with the problem are reviewed. Figures are presented suggesting that the presence of diverticular disease in a patient suffering from severe colonic bleeding may just be incidental and not always the source of the bleeding.

EFFECT OF ABO INCOMPATIBILITY ON PREGNANCY-INDUCED RH ISOIMMUNIZATION

W. L. Donohue (71 DeVere Gdns, Toronto), E. J. Wake, *Canad. Med. Ass. J.* 90:1 (Jan 4) 1964.

The protective effect of ABO incompatibility between the mother and her fetus in respect of pregnancy-induced Rh isoimmunization has been known for approximately 20 years. It has been tacitly assumed by many that this protection was, in effect, absolute and that when an infant was born with Rh hemolytic disease of the newborn and who was also ABO incompatible with his mother, there must have been a previous ABO compatible pregnancy in which the mother was initially sensitized. It also has been assumed that pregnancy-induced Rh isoimmunization could not occur if the father was AB and the mother O. The authors present data to show that both of the above assumptions are not universally true. In a detailed study of a large number of families with pregnancy-induced Rh isoimmunization, a total of nine families was found in which sensitization occurred and in which ABO incompatibility was present in every pregnancy. In addition, three families are documented in which pregnancy-induced Rh immunization had occurred and the father was AB and the mother O.

A PATIENT WITH CORONARY THROMBOSIS TREATED WITH HYPERBARIC OXYGEN

A. J. Moon (Pinewood Hosp., Wokingham, Berks, England), K. G. Williams, W. I. Hopkinson *Lancet*, 1:18 (Jan. 4) 1964.

In a 56-year-old man, severe secondary shock developed following a second coronary thrombosis. His pulse and blood pressure could not be recorded, and he failed to respond to routine methods of treatment including nursing in an oxygen tent and the administration of vasopressor drugs; the prognosis appeared very unfavorable. He was then transferred to a mobile high pressure (two atmospheres) oxygen chamber. Within two hours of this transfer, his general condition had improved greatly, and his blood pressure had risen to 100/80 mm Hg. This therapeutic procedure, with two hours in the high pressure oxygen chamber and 10 to 30 minutes outside, was continued for 48 hours, and the oxygen pressure was gradually reduced. The patient made a satisfactory recovery. The authors suggest that this high pressure oxygen therapy merits further trial. ◄



Wisconsin Summer Camp for Diabetic Children Set for July

The summer camp for diabetic children will be conducted for the 16th year under the auspices of the Diabetes Association of Greater Chicago from July 12th through August 2nd at Holiday Home, Lake Geneva, Wisconsin. Boys and girls from eight through 14 years of age are eligible.

As in previous years, the camp will be staffed by resident physicians, a nurse, two dietitians and a laboratory technician, in addition to the regular counseling and domestic staff of Holiday Home.

Rates for summer camp are arranged in accordance with individual circumstances. Applications may be obtained from, and inquiries should be directed to: Diabetes Association of Greater Chicago, 620 North Michigan Ave., Chicago 11, Ill.

New Chart on "Safe Practice In Anesthetizing Locations"

A chart on "Safe Practice in Anesthetizing Locations" has just been published by the National Fire Protection Association.

Designed for posting in hospitals, the chart describes recommended hospital regulations for equipment, personnel and practices in operating rooms and other anesthetizing locations.

The 9½- by 13-inch chart is based on NFPA's Code for the Use of Flammable Anesthetics (NFPA No. 56). It is printed on durable coated stock. Copies are available (50 cents per copy, discounts for quantity orders) from the Publications Department, National Fire Protection Association, 60 Batterymarch St., Boston, Mass., 02110.

Dr. Plain Re-elected

Dr. George B. Plain, South Bend, has been re-elected to the board of directors of the United Community Funds and Councils of America. UCFCA represents the nation's 2,200 United Funds, Community Chests and Community Health and Welfare Councils.

$250 Award Given for Best Occupational Health Manuscript

A competition for a $250 award for the best manuscript submitted by a medical student, intern or resident on any subject pertinent to and concerning occupational health has been announced by the Central States Society of Industrial Medicine and Surgery. The contest closes at midnight July 31.

A second competition, open only to residents in occupational medicine, is announced by the Industrial Medical Association. The award, consisting of an embossed scroll, will be presented at the association's annual meeting to the author or authors of a paper published in the open literature on a subject germane to occupational medicine which is judged to be the most outstanding of those submitted. Reprints entered in the competition must be published before May 31 and submitted prior to July 31.

Both contests will be judged by members of the Committee on Merit in Authorship of the Industrial Medical Association. The criteria will be largely based on clarity, validity, objectivity, originality and style. Complete contest rules may be obtained from: Industrial Medical Association, 55 East Washington St., Chicago, Ill., 60602.

Proctologic Society Elects Officers

The Ohio Valley Proctologic Society has elected Dr. A. Gerson Carmel of Cincinnati as president for 1964. Dr. Stewart R. Jones, Dr. Arthur H. Wells, and Dr. Jack D. Selzer, all of Cincinnati were elected president-elect, vice-president and secretary-treasurer.

Dr. J. M. McIntyre of Indianapolis, Dr. Henry B. Asman of Louisville and Dr. Walter J. Tims of Youngstown are members of the Executive Council.

Industrial Medicine Data Needed by Dr. Painter

Dr. Lowell Painter, Winchester, is interested in collecting suggestions and advice for an ISMA booklet which would be helpful to the general practitioner who is called upon to practice part-time industrial medicine.

Any member of ISMA experienced in this field, is invited to write Dr. Painter at 124 E. Franklin St., Winchester, Indiana.

Dr. Surratt Re-Opens Office

Dr. Mary Norris Surratt announces the re-opening of her office for the practice of ophthalmology at 1010 East 86th St., Indianapolis. The telephone number is Vi. 6-5240.

Mead Johnson & Co. Foundation Makes Grant to Deaconess Hospital

Mead Johnson Company Foundation has made a $51,000 three-year grant to the Evansville Protestant Deaconess Hospital.

The grant is to be used to integrate the existing postgraduate educational facilities of Deaconess, to expand and create new teaching facilities, to sponsor annual seminars, to improve case study technics and to make reports on new medical advances. The grant is similar to those made by Mead Johnson Foundation to St. Mary's Hospital and the Welborn Memorial Baptist Hospital for educational programs.

Tape Recordings of Heart Sounds and Murmurs Available

Nine reels of tape recordings on cardiovascular diseases are available on loan to physicians' groups. Designed as an aid to physicians in the diagnosis and treatment of cardiovascular diseases, the tapes include discussion on rheumatic fever, hypertension and other subjects, as well as actual heart sounds—both normal and abnormal.

These may be borrowed free of charge for a four-week period. Write to: Communicable Disease Center, Atlanta, 22, Georgia. If you wish your own set, send in nine new reels (7-inch dia.), each with 1,200 feet, all purpose, 1.5 mm. acetate, magnetic tape and recordings will be made and returned, free of charge.

Workshop for Registered Nurses Scheduled at Goshen College

A workshop for registered nurses with the theme "Patients Are Interesting People" will be held at Goshen College in Goshen, Indiana, from June 15 to 26. All registered nurses are invited to attend.

A tuition fee of $56.00 will be charged. Housing will be available at college dormitories at $1.00 per night. For further information nurses should write Goshen College School of Nursing. Pre-registration must be completed before May 15.

Lake County Honors Judge

Lake County Medical Society presented its Dr. Thomas W. Oberlin Award for contributions to public health to Superior Court Judge Fred A. Egan.

He was cited for his interest and attention to the mentally ill, particularly for his handling of cases of mentally ill persons in his court.

Percodan Being Placed on Class A Narcotic List

Percodan (Endo Laboratories) is being placed by Federal Regulation on the Class A Narcotic List and effective July 3, 1964, will be obtainable only upon written prescription. Oral and telephoned prescriptions will not be effective after that date.

The order includes Percodan, Percodan-Demi, Percobarb, Percobarb-Demi and Nucodan. Percodan was a Class A Narcotic until 1955. Because it was then thought to be non-habituating, it was placed in Class B. Since 1955 it has been obtainable on oral prescriptions, and in this time has demonstrated that it is habit-forming.

Quacks and Quack Remedies Hit By New Government Booklet

Quacks and quack remedies may be spotted by following the directions in a new government booklet "Your Money or Your Life."

Written to acquaint the public with the billion dollar secret remedy and false cures racket, the booklet debunks many specific rackets and also outlines general specifications to help the layman protect himself and family.

Single copies are free, multiple copies are 10 cents with 25% discount on orders of 100 copies or more. Write to Food and Drug Administration, Washington, 25, for single copy. Write and send money to Superintendent of Documents, Government Printing Office, Washington, 25, for multiple copies.

Dr. Hoyt is Rotarian Speaker

Dr. Lester H. Hoyt, pathologist and director of laboratories at Methodist Hospital, was guest speaker at the March 31 meeting of the Rotary Club of Indianapolis.

He spoke on "Where the Dead Serve the Living." Dr. Hoyt has been at Methodist since 1937.

Mead Johnson Pays $1 Million In Aid to Medical Education

Mead Johnson Laboratories has just completed the final payment on its first full million dollars in aid to medical education. A check for $20,000 was presented to the American Academy of General Practice to support the program of general practice residencies.

At the end of this residency year, 180 young general practitioners will have been trained since the origin of the residency program. Mead Johnson also grants financial support to the American College of Pediatrics, the American College of Physicians, the American College of Obstetricians and Gynecologists, the American College of Surgeons and the Student American Medical Association. ◄

Trauma Committee to Present Emergency Aid, Transport Seminar

The Committee on Trauma of the American College of Surgeons, Indiana Chapter, will present a two day training program on emergency aid and transportation of the sick and injured May 14-15 at the Indiana State Board of Health.

For further information contact William T. Brennan, Assistant Professor, Department of Health and Safety, Indiana University, Bloomington, Indiana 47405.

American Cancer Society Offers Acute Leukemia Symposium

A symposium on clinical aspects of acute leukemia will be presented May 22 in New York, N. Y. It will be jointly sponsored by the American Cancer Society and the National Cancer Institute.

Further information may be obtained from William T. Mabrey, Program Director, Indiana Division of The Cancer Society, 215 E. New York St., Indianapolis.

Aerospace Medical Association Sets 35th Annual Meeting Dates

The 35th annual scientific meeting of the Aerospace Medical Association will be May 11-14 at the Americana Hotel, Bal Harbour, Miami Beach, Florida.

On Thursday, May 14, a special panel presentation on "Aerospace Medicine and Bioengineering: A Test Pilot's Viewpoint" jointly sponsored by the Society of Experimental Test Pilots, will feature nine of the world's most famous test pilots representing aviation industry, the armed forces and federal agencies.

University of Illinois Medical Alumni Set Seminar, Banquet

The University of Illinois Medical Alumni Association will hold its annual seminar and reunion banquet during the Illinois State Medical Society Meeting, Monday, May 18, in Chicago.

The seminar will be held on the campus from 9 a.m. to 4 p.m., and the banquet will be at the Hotel Sherman at 6 p.m.

Chicago Ophthalmological Society To Present Clinical Conference

The Chicago Ophthalmological Society will present its annual clinical conference May 22 and 23 at the Drake Hotel in Chicago.

Fee for the entire conference is $50.00. Partial enrollments for either day are offered at a reduced rate. For further information, contact Mrs. Arlyne R. Schulz, 5552 N. Olcott Ave., Chicago, 60656. ◄

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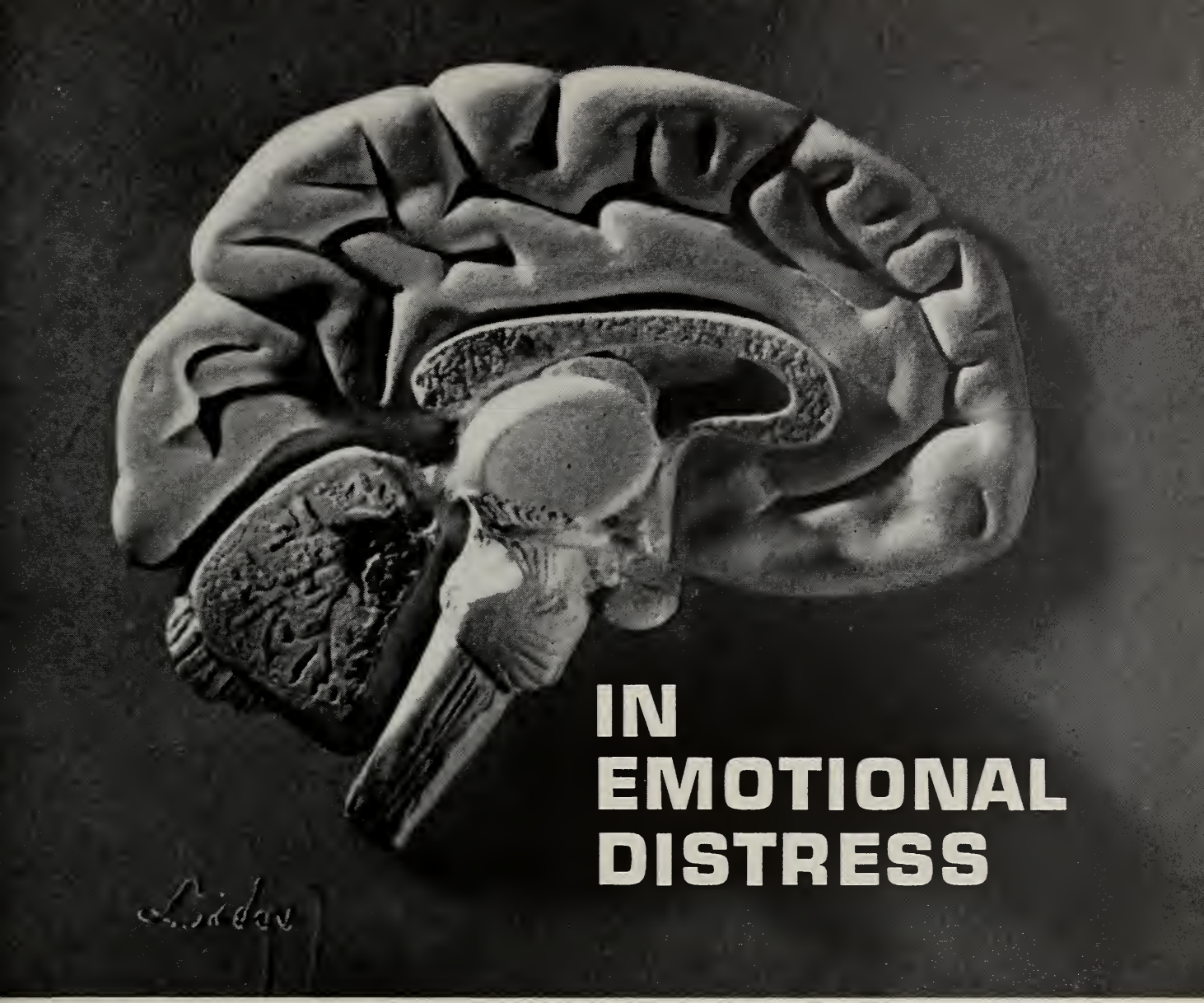
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County News

Adams

Field Secretary Howard Grindstaff attended the Feb. 11 meeting of the Adams County Medical Society to show the "Gift of Health" film.

Carroll

Dr. William B. Ferguson, Lafayette, discussed "Athletic and Developmental Injuries in School-age People" before the Carroll County Medical Society meeting Feb. 19. Coaches, physical education instructors and principals from the schools in Carroll County and Delphi were guests of the society for this special meeting.

Clay

Dr. Robert Maurer, Brazil, has been elected president of the Clay County Medical Society. Other new officers are Drs. Richard Mehne, vice-president; Forrest R. Buell, secretary-treasurer, and Rahim Farid, delegate.

Dearborn-Ohio

An orthopedic surgeon discussed "Office Treatment of Common Fractures" with the 17 members of the Dearborn-Ohio present at the Feb. 13 meeting.

Decatur

Newly elected officers of the Decatur County Medical Society are Drs. Charles Overpeck, president and Dale D. Dickson, secretary-treasurer. Both of the new officers are from Greensburg.

Dubois

Dr. Anthony Benagen will serve as the president of the Dubois County Medical Society during 1964. Dr. Allen Scales will be vice-president and Drs. Jack D. Bland, secretary-treasurer; John Barrow, delegate, and Edward Ploetner, alternate.

Elkhart

"Microsurgery of the Ear" was the topic chosen by Dr. R. V. Gunser when he spoke to the Feb. 6 meeting of the Elkhart County Medical Society.

Fayette-Franklin

The Fayette-Franklin Medical Society met March 10 to hear Dr. Archie Fine, Cincinnati radiologist, who was guest speaker.

Floyd

Drs. Lester Bibler and Robert Long, AMA trustees, presented a "Word Picture of the AMA" before the Feb. 14 meeting of the Floyd County Medical Society.

Fulton

Newly elected officers of the Fulton County Medical Society are: Drs. Dean K. Stinson, president; K. K. Kraning, vice-president; Joseph D. Richardson, secretary-treasurer; Dr. Stinson, delegate and Dr. Kraning, alternate.

Harrison-Crawford

Dr. Richard A. Jordan is the new president of the Harrison-Crawford County Medical Society. Dr. Samuel W. Martin is the new vice-president and Dr. Louis H. Blessinger, secretary-treasurer.

Howard

Dr. Thomas Conley gave a progress report on the reproductive education program in the Kokomo public schools at the Mar. 3 meeting of the Howard County Medical Society. There were 33 members present.

Jackson-Jennings

Dr. Floyd Mobler spoke on "Hip Pinning" before the Feb. 25 meeting of the Jackson-Jennings County Medical Society. There were 15 members present.

Jasper

Dr. Robert Greene has been re-elected president and Dr. Paul A. Williams secretary-treasurer of the Jasper County Medical Society. Dr. Kenneth Ockermann will serve as delegate and Dr. E. Raymond Beaver, alternate.

Jefferson-Switzerland

Field Secretary R. J. Amick discussed Kerr-Mills and King-Anderson legislation with the 24 members of the Jefferson-Switzerland County Medical Society present at the March 3 meeting.

Knox

The Knox County Medical Society has elected Drs. Richard H. Stein, president; John Anderson, vice-president; Donald T. Bartlett, secretary; Robert Nichols, treasurer; Virgil C. McMahan, delegate and Edward T. Edwards, alternate.

Kosciusko

The Kosciusko County Medical Society met Feb. 18 and voted to study the mass Sabin vaccination programs. There were 11 members present.

LaGrange

Seven members of the LaGrange County Medical Society met Feb. 18 at the LaGrange County Hospital.

Lake

Dr. Peter V. Moulder, Professor of Surgery at the University of Chicago School of Medicine, spoke on "The Cardiac Pacemaker" at the Feb. 12 meeting of the Lake County Medical Society.

Marion

Newly elected officers of the Marion County Medical Society are: Drs. Albert M. Donato, president; James M. Gosman, president-elect; Robert D. Pickett, vice-president and I. J. Kwitney, secretary-treasurer.

Miami

Dr. J. U. Guthrie has been re-elected president and Dr. C. R. Herd secretary-treasurer of the

Miami County Medical Society. Dr. H. E. Rendel will serve as vice-president; Dr. Lloyd Hill, delegate and Dr. E. E. Shrock, alternate.

Montgomery

Dr. Francis L. Sonday discussed "Speech, Language and Hearing Disorders" with the 21 members of the Montgomery County Medical Society present at the Feb. 20 meeting.

Orange

Field Secretary Amick met with nine members of the Orange County Medical Society Feb. 4 to discuss legislation and a letter writing campaign to Congressmen.

Owen-Monroe

"Headaches" was the topic chosen by Dr. J. Theodore Luros when he spoke before the Feb. 27 meeting of the Owen-Monroe County Medical Society.

Perry

The Perry County Medical Society met March 3 to tour and examine a new nursing home in Tell City which will be ready for occupancy in April.

Porter

The Porter County Medical Society met Feb. 25 to hear Mr. K. Miller, of the Indiana Division of the American Cancer Society, discuss "Cancer Detection Centers." There were 28 members present.

Randolph

The Randolph County Medical Society met Feb. 10 to view a C.P.C. movie and discuss the pathological diagnosis.

Scott

Dr. Ignacio Castro has been elected president of the Scott County Medical Society. Dr. James A. Sabens was re-elected secretary-treasurer.

Shelby

Dr. R. C. Wilmore, of the V.A. Hospital in Indianapolis, discussed "Positive Pressure Therapy in Chest Conditions" with the 22 members of the Shelby County Medical Society present at the Feb. 5 meeting.

Wayne-Union

Dr. Charles E. Kime is the new president and Dr. William Kendall secretary-treasurer of the Wayne-Union County Medical Society.

Wells

The Wells County Medical Society met Feb. 17 to hear Dr. Maurice Rougraff explain the purposes and activities of the Indiana Health Insurance Council. There were 15 members present.

Whitley

The Whitley County Medical Society met Feb. 11 with 13 members present. They discussed getting phenylketonuria testing underway. ◄

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Deaths

Robert F. Braunlin, M.D.

Dr. Robert F. Braunlin, an eye, ear, nose and throat specialist who practiced in Marion for 35 years, died Feb. 3 in Parkview Hospital, Ft. Wayne. He was 67.

A native of Portsmouth, O., Dr. Braunlin was graduated from the University of Cincinnati School of Medicine. He had served as city health officer of Marion and was a member of the Marion Police Board and the Grant County Medical Society.

Albert H. Harold, M.D.

Dr. Albert H. Harold, 86, retired general practitioner, died Feb. 5 in the Indiana Baptist Home near Zionsville where he had lived since retirement.

Dr. Harold was graduated from the Physio-Medical College of Indiana in 1905. He engaged in general practice until 1927, when he became house physician at the French Lick Springs Hotel. He served there until 1931. He then returned to general practice in Indianapolis, serving on the staffs of Methodist and St. Vincent's Hospitals. He was a member of the Marion County Medical Society. ◄

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INDIANA STATE BOARD OF HEALTH

MONTHLY REPORT — February, 1964

Disease	Feb. 1964	Jan. 1964	Dec. 1963	Feb. 1963	Feb. 1962
Animal Bites	396	340	339	293	342
Chickenpox	608	676	452	1054	593
Conjunctivitis	139	128	49	86	141
Diphtheria	0	0	0	1	1
Dysentery, Unspecified	204	113	65	219	86
Gonorrhea	333	250	293	Not Available	
Impetigo	130	96	54	96	111
Infectious Hepatitis	46	44	48	163	136
Infectious Mononucleosis	62	14	32	44	50
Influenza	1060	1402	429	12591	9752
Measles (Rubeola-Rubella)	2054	1249	464	686	755
Meningitis, Meningococcal	5	4	6	3	4
Meningitis, Other	7	8	5	5	16
Mumps	843	677	302	408	511
Pertussis	16	15	6	63	7
Pneumonia	226	237	210	316	263
Poliomyelitis	0	0	0	0	1
Streptococcal Infections	647	400	337	993	727
Syphilis					
Primary & Secondary	3	12	5	Not Available	
All Other Syphilis	103	94	94	Not Available	
Tinea Capitis	21	4	1	10	36
Tuberculosis (Active)	78	62	102	85	135

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Association News

EXECUTIVE COMMITTEE

February 19, 1964

Present: Ralph V. Everly, M.D., chairman; Don E. Wood, M.D.; Joe M. Black, M.D.; Kenneth O. Neumann, M.D.; Irvin W. Wilkens, M.D.; Ottis N. Olvey, M.D.

Frank B. Ramsey, M.D., editor of *The Journal* and J. A. Waggener, executive secretary.

Guests: Thomas O. Middleton, M.D., Bloomington; Mrs. John Sullivan, president, and Mrs. Jack Shields, president-elect, Woman's Auxiliary to the Indiana State Medical Association; Executive Committee, Indiana Hospital Association: Mr. William Hall, Sister Mary, Messrs. Edmund Shea, Arthur Malasto, Emery Zimmerman, Elton Te-Kolste, and Jack Hahn.

Minutes of the meeting of January 11, 1964, were approved on motion of Drs. Neumann and Wilkens.

Membership Report

Number of members as of December 31, 1963	4,371
1964 members as of January 31, 1964:	
Full dues paying	2,184
Residents and interns	62
Council remitted	28
Senior	320
Honorary	3
Military	47
Total 1964 members as of January 31, 1964	2,642
Number of members as of January 31, 1963	2,725
Loss over last year	83
Number of AMA members as of January 31, 1964	2,586
Total 1963 AMA members as of January 31, 1963	2,661
Loss over last year	75
1964 AMA members: Dues paying	2,129
Exempt, but active	457
Number who have paid state dues but not AMA dues as of January 31, 1964	56

Headquarters Office

Tax status. The secretary quoted from a bulletin from the U.S. Chamber of Commerce concerning cases involving associations with Internal Revenue Service on income from exhibits at their meetings.

The Medicare contract for the period beginning April 1, 1964, was approved for signature of the president upon motion of Drs. Neumann and Black.

Treasurer's Office

The treasurer gave a report on the cash balances and expenditures for the month ending January 31, 1964.

Upon motion of Drs. Wilkens and Wood, $3,000.00 is to be taken from the Building Fund and applied as advance payment on the principal of the construction loan.

Annual Convention, Indianapolis, October 13, 14 and 15, 1964

The secretary reported on the proposed entertainment program for the 1964 meeting and estimated the expense of a Gaslight party, and also an entertainment program at Clowes Hall. By consent it was agreed that the Executive Committee would recommend to the Commission on Convention Arrangements that rather than having this type of program the members of the commission consider an informal dinner and that musical talent from Indiana University be used for entertainment following the dinner.

Legislation

The president reported on the latest activity in the Congress concerning the King-Anderson bill, and Drs. Black and Wood discussed the implementation of the Kerr-Mills bill in the state of Indiana, in view of the recent Supreme Court decision and the statement released by the Governor in which he is quoted as authorizing not to implement this program until January 1, 1965. Upon motion of Drs. Wood and Black, the committee voted that the association instruct its legal counsel to take appropriate steps to seek an effective date of this law as soon as possible.

Organization Matters

Dr. Thomas Middleton, Bloomington, appeared before the committee and discussed in detail the development of southern Indiana currently in process and the health problems which many of the physicians feel will be evident through this new development. Following discussion, the president's suggestion that he appoint a committee of physicians representing all areas to meet with Dr. Offutt of the State Board of Health and the chairman of the Governor's Committee to discuss health problems which will arise as a result of this development was adopted.

Renewal of membership in the Indiana Conference on Social Welfare in the amount of $15.00 was approved on motion of Drs. Wood and Wilkens.

Request of the Indiana Association of Licensed Nursing Homes to use the association mailing list to distribute directories of the Indiana licensed nursing homes was approved on motion of Drs. Wilkens and Neumann.

The secretary read an acknowledgment from the American Medical Association of a letter sent to the AMA recommending Dr. E. S. Jones for membership on their Council on Medical Practices. The secretary reported that he had understood from Dr. Bibler that Dr. Jones has been made a member of this committee.

The request of the Commission on Voluntary Health Agencies to renew its membership in the National Information Bureau at a cost of $25.00 was approved on motion of Drs. Wilkens and Black.

The secretary was instructed to request the chairman of the Commission on Voluntary Health Agencies to represent the State Medical Association Commission at the September meeting inasmuch as he is a member of the AMA Council on Voluntary Health Agencies.

A letter was read from Dr. Robert Orr, Mishawaka, addressed to the president of the association concerning what action, if any, had been taken by the association in attempting to organize a group similar to that operating in Michigan known

as Michigan Allied Professions. The existing organizations which are similar to MAP were reviewed and upon motion of Drs. Wood and Wilkens, the committee voted to take no action on this subject at this time.

The committee discussed the proposed organization of the Indiana Health Facilities Planning Program and the resolution on this subject which had been proposed at the January meeting of the Council. Dr. Wood read a policy statement which had been issued by the Council of the Tennessee Medical Association. Upon motion of Drs. Wood and Olvey, it was agreed that the Executive Committee should formulate an appropriate resolution on ethics concerning the relationship between physicians and hospitals for submission to the Council for its concurrence.

Request of the Americans for Conservative Action to use the association mailing list for sending information to physicians with a request that they join ACA was turned down and the writer of the request was to be informed that physicians are involved in their own organization of this type and it was felt that this might be confusing.

The Journal

A letter from the State Medical Journal Advertising Bureau was read in which the association was notified that the monthly withholding on advertising placed with *The Journal* of the Indiana State Medical Association through this bureau would be increased from 14% to 19%, effective with the January 1964 billing.

Future Meetings

An invitation for two members of the association to attend a meeting of the American Medical Association on Medicine and Pharmacy, to be held in Chicago on March 12 and 13, 1964, was read, and on motion of Drs. Wood and Black, Dr. Everly and the secretary were authorized to attend this meeting.

An invitation to send representatives to the Tri-State Hospital Assembly was read and it was agreed that no representative would be sent.

Meeting with Indiana Hospital Association

The Executive Committee then met with the Executive Committee of the Indiana Hospital Association for a discussion of common problems affecting both associations.

The recent action on making the implementation of Kerr-Mills in Indiana and the Governor's action was discussed and both groups agreed that an effort should be made to have this law implemented before January 1, 1965.

The question then was discussed as to the legal liabilities of handling patients in outpatient departments. An example was given in which the hospital might call a physician and the physician request that the patient be sent to his office rather than seeing the patient in the outpatient department. The question arose as to the legal implication if a nurse attempted to diagnose a case to determine whether in her opinion the patient should be moved, or if moved and the patient died enroute where does the legal liability lie in this type of situation.

Mr. Hall, the attorney for the Hospital Association, felt that perhaps the Good Samaritan law might be amended to provide coverage for this type of situation. It was also suggested that the two associations might study the recent law which was adopted permitting the exchange of patients' records between departments in the hospital so as to provide physicians with immunity from suit or liability who were functioning as members of tissue and other hospital committees, should action taken by their committee be a cause of suspension or discontinuance of staff privileges of another physician.

The next item discussed was the proposal of the Hospital Association that the Indiana State Medical Association join with them in the operation of the Indiana Health Facilities Planning Committee. This was discussed thoroughly by representatives on both sides, the association pointing out that we had in the State Board of Health the mechanism and the authority for doing this type of job rather than establishing a separate corporation. The discussion closed with the president of the Indiana State Medical Association announcing that the Council had adopted a resolution which had the effect of supporting this activity being conducted by the State Board of Health rather than a separate corporation.

The hospital representatives then discussed the possibility of the association joining with them in an effort to obtain a more liberal definition from the Attorney General which would have the effect of permitting nurses to administer anesthetics.

The next item brought up by the hospital group was the recent legislation concerning the willing of a person's body or parts of a body. It was pointed out that with the rapid advancement of transplants and the small amount of time in which a transplant had to be made following death, they were wondering if some means could be devised similar to a "Surgical Consent" form which would have the effect of permitting the removal of an organ from the corpse for transplant immediately upon the death of the patient. It was agreed that this should be studied by the attorneys for the two associations.

The Hospital Association then raised the question concerning the association policy on I. V.'s administered by nurses. This was discussed, with no definitive action being taken.

The question then arose as to whether or not it might be wise to investigate the possibility, either by legislation or by other means, of classifying blood transfusions as a service rather than a product, it being felt that should a patient receive a transfusion and contract a condition or a disease as a result of this transfusion, if it were classified as a service the liability would be lessened, whereas it being currently classified as a

product it leaves a course open for legal action in such situations.

The president of the association then informed the Hospital Association that the policy of the Indiana State Medical Association was to continue to press for the transfer of all professional services from the Blue Cross to the Blue Shield certificate and he was hopeful that the two associations could come to an agreement on this transfer, stating that we had endeavored to make all assurances to the hospitals that we were not desirous of disrupting their arrangements other than to billing to Blue Shield rather than to Blue Cross. The president stated that he was sure additional meetings would be necessary between the two associations for further discussion of this matter and expressed the appreciation of the Indiana State Medical Association for the Hospital Association Committee taking the time to meet for the discussion of these various problems.

Meeting with Woman's Auxiliary Officers

The committee then met with Mrs. John Sullivan, president of the Woman's Auxiliary to the Indiana State Medical Association, and Mrs. Jack Shields, present-elect, at which time the program and the financial matters of the auxiliary were discussed. Upon motion of Drs. Wood and Wilkens, the committee voted to give the auxiliary $1,000.00 on May 1, 1964, to assist them in defraying the expenses of their annual meeting and their program.

There being no further business the meeting was adjourned, the committee to meet again at 6:00 p.m., Saturday, April 25, 1964, unless it is felt necessary by the chairman to call a meeting in the intervening time. ◄



Help protect the kidneys and other threatened organs

When treatment of hypertension is effective the danger of damage to the renal system is reduced.[1-2] "Hypertensive patients suffer from vascular deterioration roughly proportional to the severity of the hypertension... Reduction of blood pressure to normotensive levels reduces or arrests the progress of vascular damage with a resultant decrease in morbidity and mortality."[1] *Because Rautrax-N lowers blood pressure so effectively, it will help provide this important protection not only for the kidneys but also for the heart and brain of your hypertensive patients.* Rautrax-N is effective in mild,[3] moderate,[3,4] or severe hypertension.[4,5]

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References: (1) Moyer, J. H., and Heider, C.: Am. J. Cardiol. *9*:920 (June) 1962. (2) Brest, A. N., and Moyer, J. H.: Pennsylvania M. J. *63*:545 (Apr.) 1960. (3) Berry, R. L., and Bray, H. P.: J. Am. Geriatrics Soc. *10*:516 (June) 1962. (4) Hutchison, J. C.: Current Therap. Res. *4*:610 (Dec.) 1962. (5) Feldman, L. H.: North Carolina M. J.: *23*:248 (June) 1962.

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May 1964

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All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members. Cost of color illustrations must be shared by the author.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible. However, the right is reserved to reduce in length or reject any article.

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Communications dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 1802 North Illinois Street, Indianapolis 2, Indiana. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 3935 N. Meridian, Indianapolis 8.

Advertising rates will be furnished on request. Copy must be received by the 5th of the month preceding month of issue. (Scientific manuscripts must be received at least two weeks earlier if geared for a specific issue.)

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About Our Cover
on page 428.



15 mm. Hg. was the average diastolic drop reported following use of HYDROMOX Quinethazone in recent studies of patients with various hypertensive diseases, including essential hypertension and hypertension associated with arteriosclerotic heart disease, obesity, and renal disease.[1,2] The treatment period in one study was eight weeks[1] and in the other, twelve.[2] The lack of serious disturbances in serum electrolyte levels, particularly of potassium, was noteworthy. In fact, it was considered a sufficiently important factor to give the drug a preferential status.[2] A single daily dose of one to two 50 mg. tablets is usually sufficient.

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1. Schwartz, M.: Office Evaluation of a New Diuretic in Patients with Hypertensive Diseases. Scientific Exhibit Presented at the Clinical Meeting of the American Medical Association, Los Angeles, California, Nov. 25-28, 1962. **2.** Steigmann, F., and Griffin, R.: Evaluation of Quinethazone, a New Diuretic. *J. Amer. Geriat. Soc.* 11:945 (Oct.) 1963.

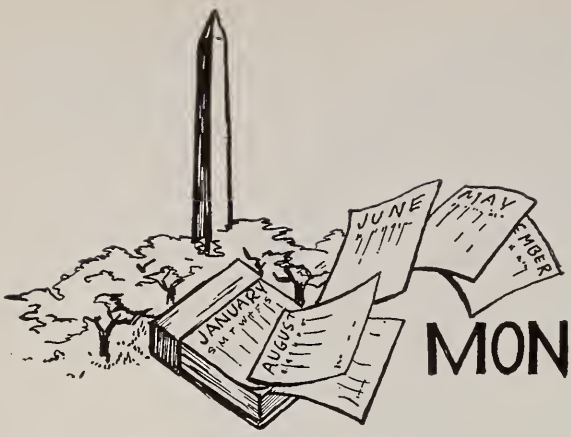
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This summary of what is happening in Washington is prepared by A.M.A.'s Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

MONTH IN WASHINGTON

WASHINGTON, D. C.—The American Medical Association has recommended to the Congress that modernization of existing hospital facilities, especially in urban centers, be emphasized in the Hill-Burton hospital construction program.

An AMA spokesman told the House Commerce Committee that a 1956 study indicated that about one-half of the nation's hospitals needed about $1 billion worth of modernization.

The committee was considering a five-year extension of the Hill-Burton program. The AMA supported the legislation but recommended changes in some of its provisions.

The AMA concurred with the provision that would combine the various types of chronic disease hospitals and nursing homes into one category called "long-term care facilities."

The AMA also supported the principle of federal guarantee of mortgages financing the cost of construction or modernization of a private non-profit hospital or other specified medical facility, or proprietary nursing home.

"The use of the guaranteed mortgage mechanism offers an incentive to local non-profit organizations to construct and improve needed medical facilities," the AMA said.

The AMA opposed a provision that would transfer to the Department of Health, Education and Welfare the Federal Housing Administration program of insured loans for construction of proprietary nursing homes.

The AMA also testified that "diagnostic and treatment centers" should be deleted as facilities eligible to participate in the Hill-Burton program.

"There is little evidence of demand for these facilities since their inclusion in 1954," the AMA said. "Moreover, the definition of the term 'diagnostic or treatment center' is vague and confusing."

The AMA urged that the traditional local determination of need and local administration of the Hill-Burton program be continued.

"The success enjoyed by the program testifies to the effectiveness of this approach," the AMA said. "The association further urges that area-wide planning for hospitals and related health facilities remain on a voluntary basis . . . It is our belief that the success of each project would be enhanced if the efforts of the local agency and the local medical society could be joined when planning the location or improvement of facilities."

AMA OPPOSES FEDERAL AID TO NURSES

The Administration asked Congress to authorize a five-year, $260 million plan of federal aid designed to increase the number of nurses in the United States.

The plan called for federal grants and loans for construction of nursing schools and training of nurses.

The American Medical Association approved in principle the construction provision but opposed loans and scholarships for nursing students.

Under the Administration plan, a total of $110 million would be spent over a four-year period on grants to construct new schools of nursing and to replace and expand existing schools. Another major feature of the bill encompassing the plan calls for spending $85 million over five years on loans to nursing students. A "forgiveness feature" would apply to 60% of the loan.

To improve nurse training and service, project grants totaling $58.8 million would be allocated over five years to public and non-profit agencies.

Other funds would be spent on planning grants to help states develop nursing programs and a limited undergraduate scholarship program.

Boisfeuillet Jones, Special Assistant to the Secretary of Health, Education and Welfare, told a House Commerce Sub-committee that it was the hope of the Administration that through passage of the bill the total number of nurses in the country—presently estimated at 550,000—would increase to 680,000 by 1970.

CANCER INSTITUTE REPORTS ON LEUKEMIA BATTLE

The National Cancer Institute has sent Congress an encouraging report on its battle against leukemia. It asked for funds for "an all-out effort toward the goal of a cure."

In testimony made public by a House Appropriations Sub-committee, Institute Director Kenneth M. Endicott said there had been a great increase in the number of children in which it was possible to arrest the disease, at least temporarily.

He told the sub-committee that improved treatments had increased the remission rate for children with acute leukemia to about 90% and had "dramatically increased the periods of their remissions and consequently their life expectancy."

Dr. Endicott said the institute, an arm of the Government's National Institutes of Health, had more than 60 children in its study group who had survived more than five years after being treated with drugs.

"Nine children out of ten who come into the institute hospital, who are usually desperately ill, go into remission, and to all intents and purposes, regain their health, go back home, go back to school and so on, at least for a time," he said.

Sub-committee members also asked Endicott about possible cancer-causing elements in such food as charcoal broiled steaks and potatoes cooked in ashes.

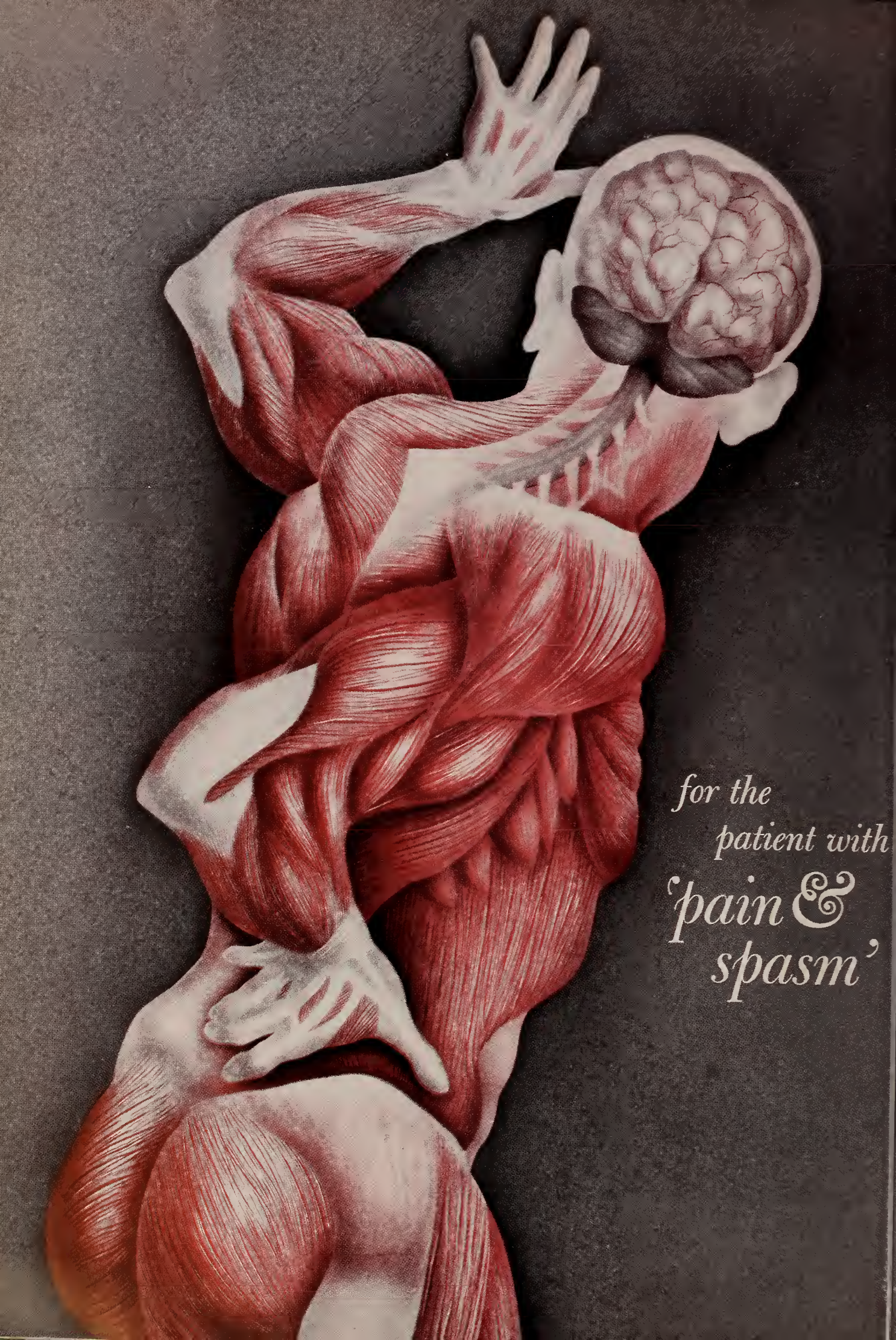
He said several laboratories had found cancer-causing agents when fats were heated to high temperatures and incompletely burned. Asked if people should stop eating such food, he said "some might draw that conclusion. I am not prepared to go that far yet."

FEDERAL COURT RULES AGAINST FALSE CLAIMS

Food and Drug Commissioner George P. Larrick hailed a federal court decision against promotional claims for vitamins and other food supplements as a landmark in the history of efforts against nutritional misinformation.

The Federal District Court ruled false many widely used promotional claims for vitamins and other food supplements after a lengthy hearing on the seizure of a quantity of vitamin and mineral capsules distributed by

Continued on page 410


for the
patient with
'pain &
spasm'

pain *is almost invariably a presenting symptom in cases of skeletal muscle* *spasm*

In some instances, the pain subsides on relaxation of the muscles in spasm. In others, relaxant therapy alone fails to give adequate relief, and supplementary analgesia (and possibly sedation) are indispensable, as in cases of:

provocative pain, when muscle spasm is triggered by some painful underlying musculoskeletal defect.

residual pain, when relaxation of severe spasticity leaves a degree of myalgia that tends to reinvoke spasm.

severe pain, when the degree of pain is such as to cause persistence of symptoms in spite of relaxant therapy.

emotionally aggravated pain, when anxiety or agitation creates tension that thwarts the efficacy of both relaxant and analgesic medication.

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Phenacetin (1½ gr.)....97 mg.
Aspirin (1¼ gr.).....81 mg.
Hyoscyamine sulfate 0.016 mg.
Phenobarbital (⅛ gr.)....8.1 mg.
(Warning: May be habit forming)



"PAIN & SPASM"
– a two-headed dragon!

ROBAXISAL and ROBAXISAL-PH are indicated in strains and sprains, painful disorders of the back, "whiplash" injury, myositis, pain and spasm associated with arthritis, torticollis, and headache associated with muscular tension.

Side effects such as lightheadedness, slight drowsiness, dizziness and nausea may occur rarely in patients with intolerance to drugs, but they usually disappear on reduction of dosage.

Contraindicated for patients hypersensitive to any component of the formulations. There are no specific contraindications to methocarbamol, and untoward reactions are not to be expected.

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MONTH IN WASHINGTON

Continued from page 407

the Vitasafe Corporation, Division of Consolidated Sun Ray, Inc., at Middlesex, N. J., in October, 1960. The seized products were labeled in part "Vitasafe Formula M," "Vitasafe Formula W," "Vitasafe CF," and "Vitasafe Queen Formula with Royal Jelly Supplement for Women."

Judge Arthur J. Lane, in his opinion, noted that labeling of the seized products represented that Vitasafe capsules were adequate and effective for the treatment or prevention of some 38 conditions, including "depression, tension, weakness, nervous disorders, lethargy, lack of energy, lassitude, impotence, aches and pains, aging, impaired digestion, loss of appetite, lesions and scaliness, night blindness, photophobia, fatigue and headaches."

"This representation is false and misleading," Lane said. "The evidence produced at trial conclusively proves that the above designated symptoms or conditions are caused by and associated with a great number of serious pathological diseases. Further, although some of these symptoms may be associated with vitamin and mineral deficiencies, the likelihood of their being caused by or associated with vitamin or mineral deficiencies in the U.S. today is very small." ◄

From The Journal 50 Years Ago

. . . Let there be erected in connection with each hospital for the insane a reception observation hospital, properly equipped with modern therapeutic appliances, laboratories, etc., to which a patient could be admitted with no more formality than now attends the admission of patients to any charity hospital, there to remain until such time as the officers consider it wise to discharge or recommend their legal committal. It is already the custom for hospitals for the insane to receive when possible all the cases from their districts, but only after due process of commitment and many times after it is too late to give the patient that benefit which earlier attention would have insured him.

* * * * *

Let these reception stations be selected and supervised by the superintendent or staff of the state hospitals. When a deranged person is placed in the observation ward, notify the state hospital and have the patient immediately visited by a member of the staff who would examine and diagnose the case, outline the treatment and determine whether it is best for him to remain in this temporary retreat or be conveyed to the state hospital at once. By this arrangement the hospital staff would be brought in closer touch with the patient's surroundings . . . his family and friends.

* * * * *

The educative influence on the people themselves would be beneficial for it would teach them that insanity is a disease and is relieved and often cured by the ministrations of a physician skilled in the art of dealing with insanity in its manifold forms. . . . Fred M. Terflinger, M.D. "The Need of a State Detention Hospital for the Early Diagnosis and Treatment of Acute Mental Diseases", *JISMA*, May, 1914.



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LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Bonus

Along with the Supreme Court's reapportionment gift, Indiana this week won a bonus prize in the form of state implementation of the federal Kerr-Mills Act.

Curiously, the court's decision in favor of the General Assembly's approval of Kerr-Mills legislation came on the day President Johnson asked Congress, once again, to approve a "medicare" bill financed through Social Security.

The Tribune urged passage of a Kerr-Mills implementation law in Indiana last winter when the legislature was in session, and the court's action in striking down Governor Welsh's veto is satisfying. The Kerr-Mills Act is a more modest approach to providing medical care for the aged than the indiscriminate Social Security proposals. It has the sensible advantage of being geared to recipients' needs.

Kerr-Mills has never really been given a chance to prove itself. It should have a chance before Congress embraces the Social Security approach to medical care. We are glad that in Indiana, at least, Kerr-Mills now will get the trial it deserves.—*South Bend Tribune,* Feb. 13, 1964.

Policing The Pills

Armed with the new powers provided by the Kefauver-Harris Drug Act, the government is seeking to eliminate quackery and misrepresentation in the pharmaceutical industry. The Food and Drug Administration has served notice that drug companies must be prepared to show that every medication that has won government approval since 1938 is effective as well as safe—in other words, that the claims made for various pills and potions bear some proximate relationship to the truth.

No doubt most drug companies are thoroughly ethical, and these firms should have nothing to fear from the FDA. But misrepresentation and downright fraud should have no sanction in an industry that earns profits from patrons who are often gullible, aged and needy.—*The Washington Post.*

Welcome First Step

Formation of United Hospital Services is a welcome first step toward cooperative cost-cutting on the part of Indianapolis' private, voluntary hospitals.

People who have expressed concern over rising bills for patient care should be glad to know that the hospital officials and civic leaders who are behind United Hospital Services have been equally concerned.

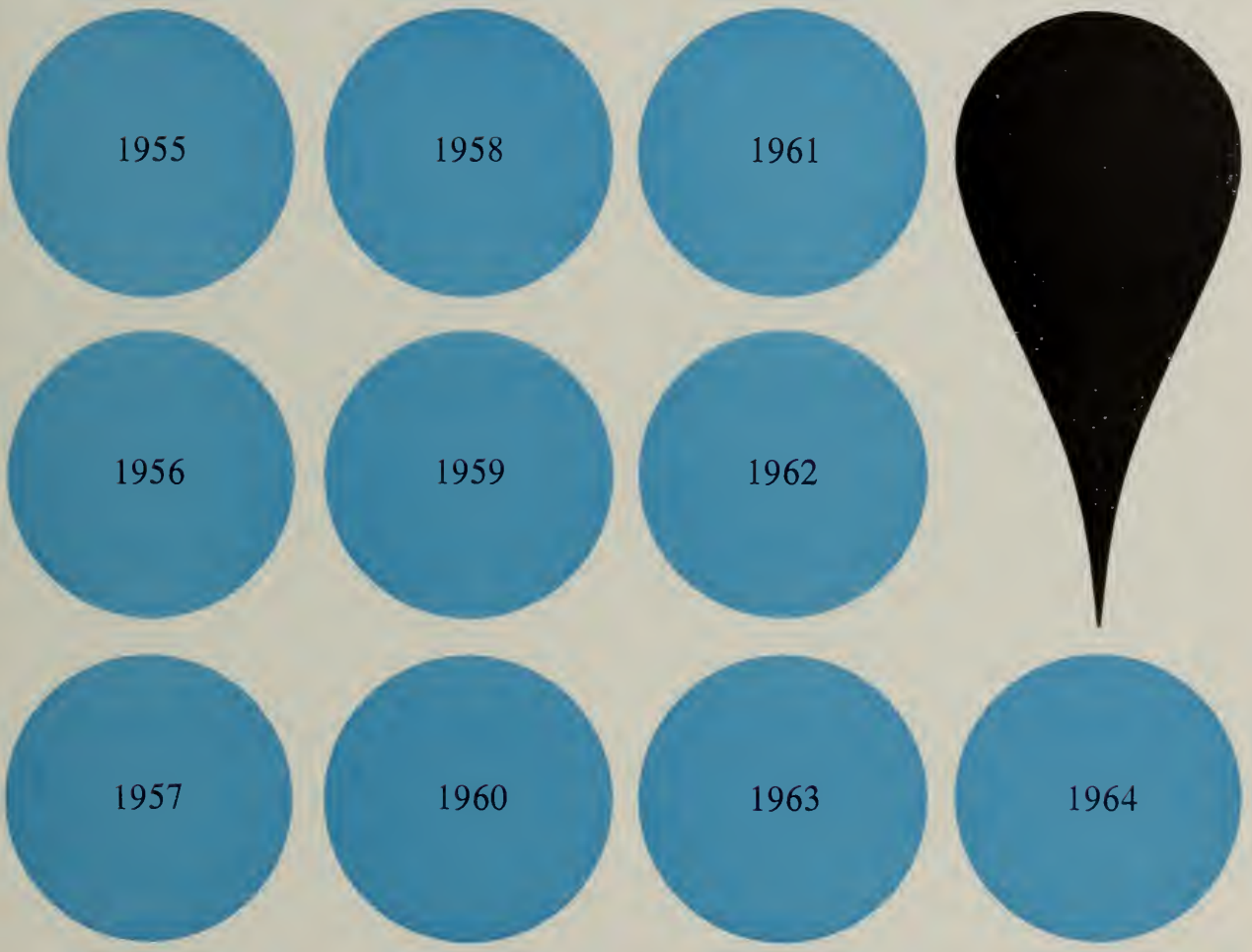
The proposal to pool certain facilities into central operations has been under study for some time and has received editorial encouragement from *The News.* Now we are more than pleased to learn that the studies support both feasibility and economy of a long-range program.

The first joint project will be a centralized laundry facility expected to be in operation within eight months. It is estimated that this will cut laundry costs—a major expense item of our hospitals—by $200,000 to $300,000 a year.

Eventually, the organization expects to centralize other services which now are conducted separately at a far greater total cost. These may include computer and data processing, food, drug and equipment purchasing, building maintenance, blood bank, record storage and educational programs

Continued

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for nurses and other personnel.

While this first incorporation of United Hospital Services involves only private hospitals, the organization's directors have extended a special invitation to officials of the public hospital and medical facilities in the city to participate as their programs permit.

The Indiana University Medical Center complex has plans for $23 million expansion and Marion County General Hospital for $16 million in enlarged buildings and services. The whole United Hospital Service centralization economy project has been tailored, in fact, to the possibility that the public institutions may also come in. We hope that this may become possible, to the benefit of the public, the patients and the institutions themselves.

We believe that cooperative economy of this sort is mandatory if our people and our hospitals are to meet the rising demand for patient care, both as a family problem and as a community problem.—*Indianapolis News,* March 27, 1964.

Medicare Again

One prediction being offered for the New Year is that the so-called "medicare" bill, imposing additional social security taxes for "free" governmental health services, will be revived.

That announcement wakes memories of the frantic agitation to which the country was subjected two years ago, as we were informed that literally millions of people were victimized by high medical costs and therefore deprived of the attention they needed.

Anti-medicare forces pointed out in rebuttal that private health insurance now covered the vast majority of the population, and that medical care for all and sundry was better than ever.

Now comes some interesting intelligence, courtesy of the *Wall Street Journal,* reflecting on the merits of this controversy. According to a story in last Friday's *Journal,* charity patients are virtually disappearing from America's hospital wards. A few years ago, one in every three hospital patients was a charity case; now the figure is around one in five, and continues to diminish. *The Journal* story says: "This continues a steady decline in charity cases over the past two decades, attributable largely to the rise in health insurance coverage."

In fact, the decreasing number of charity patients has become something of a problem. Charity wards have traditionally been the scene of much dedicated work by interns and resident physicians giving of their time in order to learn more about their profession. They have been, in the highest sense, training grounds for the advancement of medical knowledge.

With the disappearance of charity patients, this training experience is less and less available to the hospitals. "Paying patients," the *Journal* notes, "including those covered by health insurance, normally have their own private doctor." Even though an intern can participate in the care of such cases, the private doctor naturally has final and controlling authority.

The Journal cites the following figures to suggest the magnitude of the change: "At Los Angeles Childrens Hospital, one-third of all cases in 1962 received free care, down from about one-half in 1955 and 78% in 1940. New York's Montefiore Hospital reports that free patients last year dropped to a fourth of all cases, down from about one-half in 1947. At Jewish Hospital in St. Louis, charity patients are only 13% of total cases, down from 30% a decade ago."

Those figures suggest the misleading alarmism of the demand for government health "insurance." In point of fact, if the rapid spread of private medical coverage suggested by these data is projected into the future it is apparent that in a very few years there will be only a tiny fraction of the population which does not have such coverage.

Yet to take care of this fraction, it is demanded that the entire population with social security coverage be blanketed into a compulsory governmental program!—*Indianapolis News,* Dec. 30, 1963.

Dr. John D. VanNuys

The untimely death of Dr. John D. VanNuys means a great loss to the medical pro-

fession, to the state of Indiana, to his family to which he gave deep devotion, and to his wide circle of friends and admirers.

The dean of the Indiana University Medical School enjoyed nation-wide esteem as a medical educator. To his professional colleagues he was "the doctor's doctor." More than one-third of his 56 years was devoted to I.U.'s Medical School, as student, as administrator and as teacher. He became dean in 1947.

His father and grandfather also were doctors. The third generation of the VanNuys family carried on in the finest tradition.—*The Indianapolis Star,* Feb. 16, 1964.

This Is Not "Whit and Humer"

The student who can write of a man's "noze" or his "whit and humer" apparently is no oddity in any freshman class in any American university. Nor is it the exception to find examples of fractured English such as this one that appeared in instructions to prospective teachers in a course in educational psychology:

"It is suggested that you claim a seat within the first week. The instructor has no preference where you sit, however, to facilitate the taking of roll a permanent seating chart will be organized after the first week."

In the headlong rush to improve science and mathematics instruction, English seems to have been left behind.

One out of four University of Minnesota students who took a recent test could not understand or use basic rules of grammar. The same number were unable to organize and present a subject in orderly fashion.

The problem is rooted, of course, in the poor quality of English instruction. A majority of English teachers questioned in one recent study said they did not consider themselves well prepared to teach composition and oral skills; 90% felt they were inadequately prepared to teach reading; almost half conceded that they were not prepared to teach literature and language. This survey was conducted by the National Council of Teachers of English which claims 80,000 members.

The gravity of the situation was underscored by Francis Keppel, United States commissioner of education, in a Chicago speech.

"The shortage of adequately prepared teachers in English is likely to undermine the quality of American education for a generation to come unless immediate measures are taken to remedy the situation," he said.

One suggestion is to expand the national defense education act to include aid for the humanities. The act is now confined to support for instruction in foreign languages, science and mathematics.—*Milwaukee Journal,* reprinted in *Indianapolis Star,* March 5, 1964.

Dr. John D. VanNuys

The field of medical education and the medical profession have lost an outstanding figure in the death of Dr. John D. VanNuys.

His notable career has ended prematurely at 56. A nationally known medical educator, he had served as dean of the Indiana University Medical School since 1947. Under his guidance, this great institution has enhanced its fine reputation, ranking as one of the top medical schools of the nation.

In his administration of the school, Dr. VanNuys, a personable man, won the confidence of the medical profession in Indiana because of his ability and energy. The devotion of his life to the field of medicine was the natural course for him to follow, since both his father and grandfather had been doctors.

Because of his work, graduates of the I.U. Medical School have received as fine an education in their profession as it is possible to provide.

His death is a sad loss, not only to medical education but to the entire state, of which he was a leading citizen—*Indianapolis News,* Feb. 17, 1964. ◄



"Leakers" are ampoules with minute imperfections in the seal. You can't readily see the flaw, and often it's so small that liquids won't even drip through; but microscopic contaminants can slip in to render the contents nonsterile and potentially dangerous. ▪ Detecting "leakers" is the job of the vat and the blue dye. ▪ Sealed Lilly ampoules are placed in baskets, submerged in a vat containing methylene blue, and subjected to a vacuum. If there is an imperfect ampoule in the lot, the liquid is forced out. When the vacuum is released, the blue dye rushes in. ▪ With dye as the spy, elusive "leakers" are quickly spotted and rejected . . . another of the many controls that add immeasurably to the quality of the finished product.

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Clinical Tetanus: Treatment of Ten Cases

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TETANUS is a potentially fatal disease which has been known to mankind for centuries. Although great strides have been made to decrease its incidence by both active and passive immunization, therapy of the established disease remains symptomatic. The purpose of this paper is to show that surgical debridement combined with serotherapy, sedatives, antispasmodics, antibiotics, meticulous nursing technics and general supportive measures along with constant medical supervision can yield satisfactory results in the great majority of cases.

In the five-year period since 1958, ten adult patients with tetanus have been admitted to the Indiana University Medical Center. They were all admitted to the medicine service but were seen in consultation by surgery, anesthesia, ENT, and physical therapy. There were seven males and three females ranging in age from 16-68. All patients were Caucasian.

Results

The incubation period ranged from four-16 days in nine patients (Table 1). One female (AH) sustained a washing machine injury to her left arm, which resulted in several lacerations with subsequent eschar formation, infection and clinical tetanus 120 days following her initial injury. None of the patients were known to have had previous tetanus immunization. One male (JM) was 19 years old at the time of admission and stated that he had had "baby shots" at the age of three. This patient is known to have received 0.5 cc. tetanus toxoid from his physician at the time of his injury (seven days prior to admission). All patients had a potential source of infection, and debridement was performed after admission to I.U.M.C. in all except one patient (BK), who died on the day of admission. Cultures of the wound grew Clostridium tetani in only one patient (DS).

Trismus was present in all 10 patients at the time of admission (Table 2). The next most common significant finding was nuchal rigidity (eight cases). Opisthotonos and generalized tetanic seizures were present in one-half of the patients at the time of admission. Risus sardonicus, the characteristic facial grinning appearance, was present in only two patients. Eight patients had elective tracheotomy. One female (EP) had a mild case of tetanus, and tracheotomy was not considered necessary. The other patient (DS) died of respiratory complications and cardiac arrest on the day of admission as a result of delayed management without tracheotomy.

If the two deaths are omitted, the days of hospitalization ranged from 17-56 with an average of 35 hospital days. Serum sickness occurred in six of the eight patients (75%) who survived long enough for the

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Patient	Age	Color Sex	Incubation Period (Days)	Previous Tetanus Immunization	Wound	Wound Culture	Debridement	Blood Culture
JM	19	WM	6	?	Crushed right thumb.	Not done	Done	Not done
EP	68	WF	16	None	Severed left index finger.	Negative	Amputation of left index finger.	Not done
JW	54	WM	7	None	Lacerated right index finger.	Not done	Done	Negative
MI	18	WM	6	None	Trauma to mouth.	Not done	Done	Negative
AH	66	WF	?	None	Washing machine injury to left arm.	Negative	Done	Not done
BK	22	WF	8	None	Laceration of right foot.	Staph. aureus, coag. positive	Not done	Klebsiella
GO	16	WM	4	None	Papules on legs.	Staph. aureus, coag. positive	Scabs removed.	Not done
DS	43	WM	12	None	Compound fracture, right tibia.	Clostridium tetani	Done	Negative
CD	67	WM	7	None	Abrasion, right forearm.	Not done	Done	Negative
NW	51	WM	7	None	Crushed left ring finger.	Negative	Amputation of digit.	Not done

TABLE 1

manifestations of serum sickness to become evident. Thrombophlebitis occurred in two patients. Wrist drop and bronchopneumonia (Staphylococcus aureus, coagulase positive) occurred in single cases as other complications. Complete recovery was seen in eight of the patients (80%).

Treatment

Immediately following the diagnosis of tetanus, the patient is transferred to a dark quiet room and is under constant medical vigilance while the necessary therapeutic procedures are being carried out. The diagnosis of tetanus is necessarily entirely clinical.

Airway: It has been our policy to have tracheotomy performed routinely in all patients with tetanus immediately following hospitalization. Elective tracheotomy aids in aspiration of secretions, prevention of pneumonia and atelectasis, and maintains an adequate airway if assisted respirations are necessary. A special fitting on the tracheotomy tube which will adapt to mechanical respirators is made available.

Ventilatory assistance is given with the Mörsch piston respirator or the Bennett respirator if hypoventilation occurs as a result of progression of the disease or secondary to the effects of respiratory depressant drugs. Hypoxemia can be detected clinically by physical examination or, more accurately, by the analysis of arterial blood for oxygen saturation, pCO_2, and pH. Arterial puncture can be performed by one adept in this procedure with a minimum of trauma to the patient.

Humidification of the tracheobronchial airway is maintained with a heated nebulizer which decreases the drying effects of oxygen on the endobronchial mucosa. Aspirations of the trachea are performed with large bore sterilized catheters every 30-60 minutes as necessary with 2-3 cc. of normal saline being instilled into the trachea each time to thin secretions. A sterile catheter is used with each aspiration, but the same

Patient	Nuchal Rigidity	Trismus	Opisthotonos	Tetanic Seizures	Trache-otomy	Hospital Days	Complications	Hospital Course	Treatment Tetanus Antitoxin
JM	Present	Present (risus sardonicus)	Present	Present	Yes	56	Thrombophlebitis, serum sickness.	Complete recovery	150,000 units IV
EP	Absent	Present	Absent	Absent	No	17	Thrombophlebitis, serum sickness.	Complete recovery	65,000 units IM 20,000 units IV
JW	Present	Present	Present	Present	Yes	24	Serum sickness.	Complete recovery	100,000 units IM
MI	Present	Present	Present	Present	Yes	32	Serum sickness.	Complete recovery	50,000 units IV 50,000 units IM
AH	Absent	Present	Absent	Absent	Yes	50	None	Complete recovery	40,000 units IV 40,000 units IM
BK	Present	Present	Present	Present	Yes	1	Shock with Gram-negative Septicemia.	Died	100,000 units IV
GO	Present	Present	Absent	Absent	Yes	35	Serum sickness, Left wrist drop.	Complete recovery	50,000 units IV 50,000 units IM
DS	Present	Present	Absent	Absent	No	1	Cardiac arrest.	Died	50,000 units IV 50,000 units IM
CD	Present	Present (risus sardonicus)	Present	Present	Yes	42	Bronchopneumonia.	Complete recovery	75,000 units IV 75,000 units IM
NW	Present	Present	Absent	Absent	Yes	26	Serum sickness	Complete recovery	50,000 units IV 50,000 units IM

TABLE 2

catheter should not be used in both mouth and trachea. The inner cannula of the tracheotomy tube should be removed and cleaned every hour, and the outer cannula should be changed daily.

All attendants should be thoroughly instructed in the proper technics of aspiration which should include aspiration of both bronchi. Frequent movements of the patient will stimulate the expectoration of dormant amounts of mucus and secretions.

Serotherapy: A skin test with the intradermal injection of 0.1 cc. of 1:1000 dilution equine antitoxin is applied and read at 15-20 minutes. If positive, as manifested by erythema and/or wheal formation, the patient should then be tested with bovine serum. If bovine serum is not available for testing, or results in a positive reaction, or if the patient has known hypersensitivity to both equine and bovine serum, desensitization should be carried out with equine serum unless human tetanus immune globulin is available.

Desensitization involves subcutaneously injecting very small diluted doses of antitoxin and gradually increasing the dose each 15 minutes to tolerance levels over an approximate three-six hour period. Following prolonged desensitization, or if the skin test is negative in the beginning, 50,000 units of tetanus antitoxin are administered intramuscularly and 50,000 units are administered intravenously in 500 cc. isotonic saline or five percent dextrose solution over a four-hour period. One milliliter of 1:1000 epinephrin is placed in the bottle.

It should be remembered that a negative antitoxin skin test indicates that an immediate anaphylactoid reaction is unlikely but has no prognostic significance in evaluating delayed hypersensitivity. Also, tetanus antitoxin is used only to neutralize the circulating toxin and will not neutralize toxin which is already fixed in the central nervous system. We do not give tetanus antitoxin after the first day nor do we give intrathecal antitoxin.

Antibiotics: Aqueous penicillin, 400,000 units, or 500 mg. erythromycin (Ilotycin Glucoheptonate) can be administered every six hours into the tubing of a continuous intravenous infusion. This avoids the potentially dangerous stimuli of intramuscular injections. A history of previous penicillin or drug sensitivity should be sought. A change of antibiotics may be necessary as determined by culture and sensitivity studies on subsequent infections. Antibiotics are given for seven-ten days unless more prolonged need is indicated.

Sedation: Secobarbital sodium has been the mainstay of sedation in our experience. The dosage requirement to control tetanic seizures varies with the individual, but approximately 50-150 mg. intramuscularly are administered every three-four hours. Further control is obtained by placing 1000 mg. secobarbital sodium in 500 cc. of five percent dextrose solution and connecting this "piggy back" to a continuous intravenous drip. This method enables one to "titrate" the amount of secobarbital sodium necessary to prevent tetanic seizures which occur during periods of stress. Undulating periods of muscle spasm can be markedly decreased with this method due to the rapid action of intravenous secobarbital sodium.

Chlorpromazine (Thorazine) is used, 50-100 mg. intramuscularly every three-four hours, to potentiate the effects of secobarbital sodium. We have observed a decreased dosage requirement of secobarbital sodium when chlorpromazine has been used. A level of consciousness which will minimize spasms without compromising ventilation or circulation is the goal of sedation. A desired level of sedation can be compared to "light sleep." As spasms continue to decrease, the dosage of sedation necessary will become less. Mephenesin (Tolserol), six-ten grams intravenously over 24 hours, and/or meprobamate (Miltown), 400 mg. intramuscularly every four hours, are used as muscle relaxants, but in our experience, have not altered significantly the clinical course of tetanus.

We have not found other combinations of sedatives and/or antispasmodics to show any significant advantages over the above-mentioned regimen.

Debridement: Surgical debridement of all wounds is performed when the primary wound site is found. This includes meticulous cleansing of abrasions and incision and drainage, if necessary. Small wounds are excised and left open to heal by secondary intention. Specimens are taken for both aerobic and anaerobic cultures (this is done before antibiotics are started). Normal saline compresses are applied to the wound area four times daily, and two percent hydrogen peroxide, an oxidizing agent, is used to irrigate wounds four times daily. We have not routinely injected the wound site with tetanus antitoxin.

General Supportive Measures: The nurse should become familiar with proper technics in the management of tetanus, and a medical attendant (intern, resident, or staff doctor) should supervise the care of the patient and be immediately available. Necessary procedures should be performed with a minimum of noise and external stimuli. Accurate records of drugs, including dosage and time of administration, should be kept. A graphic summary of this record at the end of a 24-hour period will aid the physician. Accurate graphs depicting blood pressure, pulse, respirations, temperature and intake and output of fluids are essential. Pulsating mattresses, turning the patient every two hours, and careful skin care will result in a decreased incidence of decubiti. Methylcellulose, two drops in each eye twice daily, will prevent corneal ulcers in patients with partially open palpebral fissures. An ex-dwelling catheter is used, if possible, to prevent spillage of incontinent urine onto the sheet. If the patient develops urinary retention, an in-dwelling urethral catheter may be necessary. The visceral stimulation produced by an in-dwelling catheter must certainly be less than the stimulation produced by a distended bladder or repeated urethral catheterizations. Tap water enemas are given every third to fourth day to avoid fecal impactions which may stimulate spasms.

It has been our policy to maintain the nutritional needs of the patient with intravenous fluids containing the necessary calories, vitamins and electrolytes. We have found that severe tetanic seizures prevent

the free flow of fluids and prefer an indwelling catheter in a larger vein, e.g., femoral or subclavian veins. This can be placed by the percutaneous route with a Deseret intracath or "surgical cutdown" and allows free titration with intravenous secobarbital sodium when necessary. Oral feedings are avoided until the patient can feed himself without inducing painful trismus or enhancing the possibility of aspiration pneumonitis.

Recovery

When tetanus improves, as manifested by decrease in generalized spasms, decrease in dosage of sedation, return of consciousness, and awareness of surroundings, an optimistic attitude with continued reassurance by the physician is essential. This will aid in preventing or decreasing the amount of apprehension frequently present in these patients upon "awakening" from prolonged sedation. Oral feedings can be given as tolerated. The tracheotomy tube can be closed off gradually and then completely removed. Physical therapists can aid in restoring the normal functions of the body following prolonged bed rest through passive and active movements as indicated. Tetanus toxoid, 0.5 cc. alum, precipitated or fluid, is given intramuscularly at the time of discharge and at monthly intervals for the next two-three months.

Discussion

Two of the 10 patients died on the day of admission. One of these (BK) died with Gram-negative septicemia complicated by vascular collapse, an entity which, in itself, carries a high mortality. The other patient (DS) died with respiratory complications and cardiac arrest, a death which might possibly have been prevented by prompt tracheotomy and adequate ventilation. This patient was thought to have a "mild" case of tetanus at the time of admission.

It has been stated that a short incubation period, less than five days, carries a significantly greater mortality.[1] The incubation period of these two fatalities was eight and 12 days, respectively. Perlstein, Stein, and Elam[2] have stated that the mortality is greater than 80% in patients when generalized spasms appear within 24 hours after the first symptom, e.g., backache, stiff neck or trismus, regardless of the therapy used. Neither of the two patients that died had an explosive onset of spasms. In fact, patient (DS) did not manifest spasms at the time of admission. The death of these two patients tends to confirm our contention that "mild" tetanus is extremely difficult to assess and should be treated as potentially fatal.

It has been the policy at the Indiana University Medical Center to administer between 80,000 units and 150,000 units of tetanus antitoxin, divided intravenously and intramuscularly, on the day of admission. Cooke and Jones[3] have shown that after the injection of 10,000-150,000 units, the tendency is for tetanus antitoxin to persist in the blood stream in a titer of 0.1 unit per ml. for four-eight weeks, and 0.1 unit or greater per ml. is generally accepted as the protective level of circulating antitoxin. Therefore, it is felt that the initial injection on the day of admission should be adequate and subsequent injections would only increase the possibility of anaphylactoid reactions. There is no universal agreement on the amount of tetanus antitoxin necessary. Patel et al.[4] has shown no significant difference in mortality (overall or according to grade) among groups treated with 60,000, 20,000, 10,000, or 5,000 units of tetanus antitoxin. Vener and Bower[5] recommend 200,000 units and others[6] have shown a 23% mortality in 22 patients using no tetanus antitoxin.

Penicillin and erythromycin have been used as antibiotics of choice in the treatment of tetanus. Diaz-Rivera et al.[7], using penicillin as an adjunct treatment in 17 patients, reported a gross mortality rate of 23.5%. Another group[8] reported a mortality of 16% in 100 patients treated with erythromycin in addition to the standard treatment of the disease. Tetracyclines are used occasionally.

Our armamentarium has included secobarbital sodium as the sedative of choice, both intramuscularly and intravenously. We especially advocate the method of "titrating" spasm control with intravenous secobarbital sodium drip described herein. Although our experience is limited with

meprobamate, others[2] prefer intramuscular meprobamate (Miltown) which they state, "does not cause the soporific effects of barbiturates, markedly decreases the need for barbiturates, and controls seizures due to somatic stimuli such as pin pricks, loud noises, and flashing lights." Shanker and Mekrotora[9] reported a decrease in mortality and morbidity when 50-100 mg. chlorpromazine (Thorazine) was given intramuscularly twice daily.

We now advocate routine performance of elective tracheotomy in tetanus patients at the time of diagnosis, regardless of severity. In a previous report from this institution by Jowitt[10], six out of 13 patients died without tracheotomy. It is interesting that none of the patients with tracheotomy died in his series. The medical literature appears replete with advocates of routine tracheotomy from many authors citing great reduction in mortality utilizing this aspect of treatment.

Segar et al.[11] has reported 10 consecutive successful recoveries following tetanus when constant medical supervision and excellent nursing care were employed. The significance of constant, conscientious nursing care cannot be denied. One series[12] cited 21 cases of tetanus. Eleven were cared for in a hospital with excellent nursing care with only one fatality, while in the group of 10 patients who were cared for in a hospital with an inadequate nursing staff, there were nine fatalities.

Summary

Ten adult cases of clinical tetanus have been admitted to the Indiana University Medical Center since 1958. Eight recovered completely, and two died on the day of admission. Our therapeutic regimen consists of elective tracheotomy, serotherapy, surgical debridement, antibiotics, sedatives, antispasmodics, analgesics, and general supportive measures with meticulous nursing care and constant medical supervision.

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The Surgical Treatment of Hiatal Hernia Complex

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IN PREVIOUS PUBLICATIONS, we[1,2,3,6,7] defined the various types of esophageal hiatal hernia and noted that the common denominator in most cases producing symptoms is a cephalad displacement of the cardia of the stomach with a loss of the esophago-gastric angle. The purpose of this paper is to re-emphasize the fact that symptomatic hiatal hernia in itself is only a part of a disease complex which requires several surgical procedures at one time for its correction.

Pathological Considerations

Hiatal hernia itself is an anatomical defect which may or may not produce symptoms unless it is of enormous size. But symptomatic hiatal hernia is usually a part of several related abnormalities.[4,5,6]

The most commonly associated disease in hiatal hernia is esophagitis. However, patients with hiatal hernia may have symptoms requiring surgical treatment, and patients without hiatal hernia may have the same symptoms requiring the same surgical treatment. Moreover, the hiatal hernia may vary in type (Table I). Hiatal hernia, therefore, is not the sine qua non of peptic esophagitis though it may be a contributing factor. It may even be the major contributing factor.

Unless the hiatal hernia is monstrous, it is better to approach the problem as one of peptic esophagitis. Peptic esophagitis occurs when the esophageal epithelium becomes inflamed due to a variable admixture of the following ingredients:

(A) Resistance
(B) Digestive Juices
(C) Time

Expressed as a simple equation $\frac{D + T}{R} = I$, where R = resistance, D = digestive juices, T = time and I = inflammation.

Although less important, the anatomical components must be considered. The anatomical components are:

(a) Hiatal hernia (displacement)
(b) Dilated esophageal hiatus
(c) Derangement of the esophago-gastric angle
(d) Pyloric spasm or stenosis
(e) Differential in abdominal and thoracic introgastric pressures.

For the purpose of the equation these components are added to the numerator: $\frac{D + T + (a + b + c + d + [e])}{R} = I.$

We would emphasize, however, that it is not the size of the hernia, the degree of acidity, or the quantity of juice that is important, but rather the continuity of regurgitation day and night. In fact, alkaline digestive juices may also invite chemical ir-

INCIDENCE OF VARIOUS TYPES OF HIATAL HERNIA IN 300 CONSECUTIVE SURGICAL CASES

TYPES OF HIATAL HERNIA	NUMBER REQUIRING BALANCED PROCEDURE	PERCENT
Sliding (acquired short esophagus of brachyesophagus)	270	90%
Hiatal hernia en masse (combined hiatal and parahiatal)	18	3
Parahiatal (para-esophageal, rolling)	9	6
Congenitally short esophagus	2	0.7

TABLE I

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ritation in the esophagus, with secondary infection.

The concept of hiatal hernia complex is further substantiated by the association of hiatal hernia with achalasia and cardiospasm, lower esophageal rings (Schatzke-Ingelfinger), megaesophagus and dolechoesophagus, epiphrenic and midesophageal diverticula, gastritis and gastric ulcer, duodenitis and duodenal ulcer, biliary tract disease and pancreatitis (Table II).

Indications for Surgical Intervention

Many patients with hiatal hernia have surprisingly few symptoms. These asymptomatic types of hiatal hernia are usually found on fluoroscopic observation with the Valsalva and "sniffing" maneuvers or x-ray examination, particularly made in the Trendelenburg position.

Usually, however, patients complain of postprandial epigastric or substernal pain, "heart burn", regurgitation and pyrosis. Severe cases may regurgitate and aspirate, producing cough and dyspnea; or they may have weakness due to occult bleeding. Regurgitation and pyrosis, as we have stated, may occur without hiatal hernia and result in esophagitis (Figure 1).

In a previous report we stated that only 30% of hiatal hernia patients needed surgery.[6] We did recognize, however, that symptomatic hiatal hernia may be a progressive disease, and our indications for surgery were as follows:

(a) The persistence and progression of symptoms in spite of adequate medical management. Patients not controlled by a proper medical regimen usually have a severe associated esophagitis or other disease in the stomach, biliary tract, or in the pancreas;

(b) Complications of esophagitis such as stenosis, bleeding and perforation;

(c) Lesions for which surgery is indicated, particularly in the esophagus, stomach, duodenum, pancreas, gallbladder and bile ducts. We cannot be sure of the role the hiatal hernia plays in the production of symptoms.

The important fact about our increasing experience is that 20.9% of the patients with few symptoms, or with discomforts which could be controlled readily by medical management, became progressively worse or developed severe complications or associated disease which demanded surgery. This was frequently observed in the so-called post-cholecystectomy syndrome.

Moreover, eight patients in this group developed stenosis or stricture of the lower



FIGURE 1

PRE-OPERATIVE FILM showing high degree of regurgitation, loss of cardio-esophageal angle, hiatal incompetency and esophagitis. Balanced procedure performed with excellent results. Note pylorospasm without demonstrable ulcer.

HIATAL HERNIA COMPLEX TREATED BY SURGERY ASSOCIATED LESIONS (ONE OR MORE) IN 300 CONSECUTIVE PATIENTS

ORGAN	NUMBER OF CASES	PERCENT
Esophagus	270	90%
Gallbladder	78	26
Duodenum	60	20
Bile Ducts	36	12
Pancreas	24	8
Stomach	15	5
Liver	9	2

TABLE II

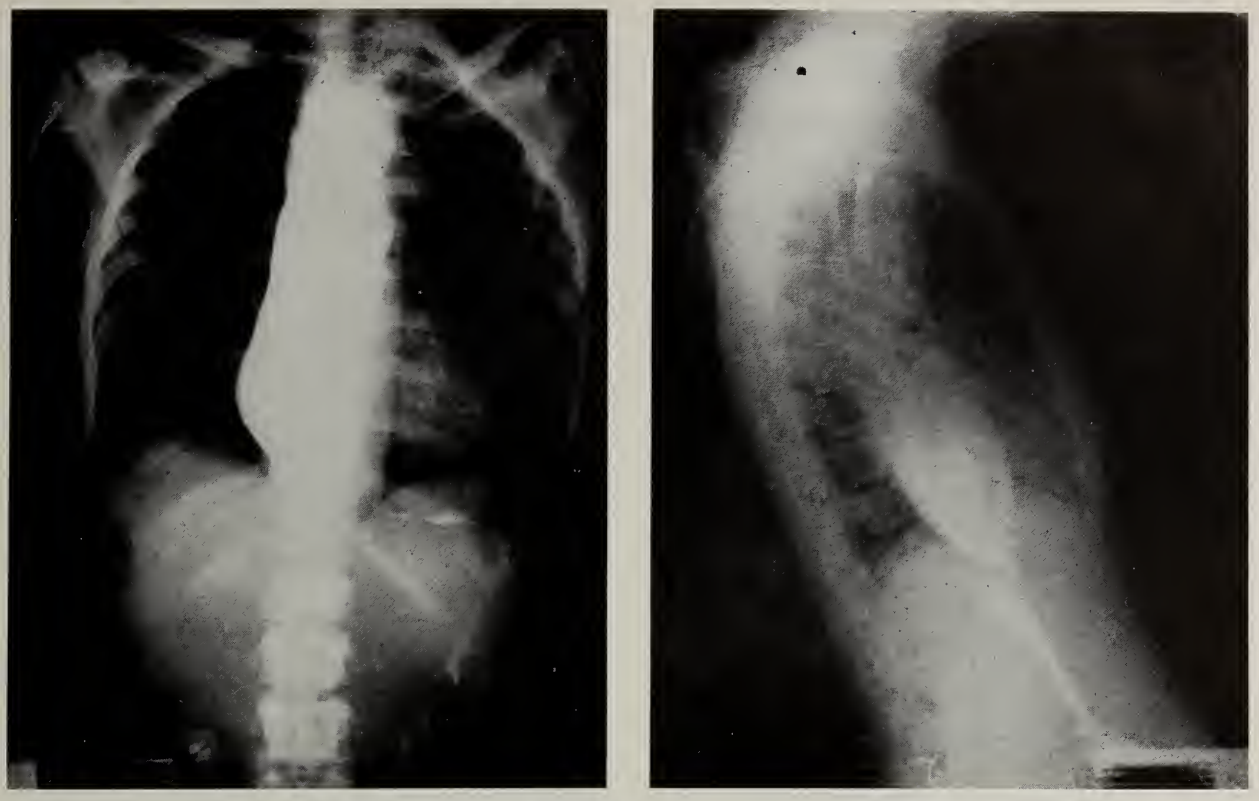


FIGURE 2

MEGAESOPHAGUS and dolechoesophagus with esophageal stenosis. (A) PA film showing barium swallow 15 minutes after the administration of amyl nitrite. There is no relaxation of spasm. (B) Lateral view.

esophagus with megaesophagus, and two also had dolechoesophagus (Figure 2, A, B).

Seven developed epiphrenic or midesophageal diverticula which required combined thoraco-abdominal operations. Two had severe periesophagitis, so that the stomach could not be brought down through an abdominal incision alone.

In the light of these experiences, we believe that surgery is indicated in all symptomatic hiatal hernias. If no symptoms are present, patients should have fluoroscopic and x-ray examinations at intervals, but surgery is not indicated unless the hernia is increasing in size.

Surgical Procedure

Hiatal hernia complex is a multifaceted problem of organic and functional derangements. Therefore several operative procedures are necessary at one time to obtain maximum improvement. We have called this operation "balanced" for lack of a better term, because we combine several procedures at one time to correct unphysiological mechanisms.

In all cases we replace the stomach in its normal position, if at all possible. This is important to prevent reflux due to differentials in abdominal-thoracic pressure.[4] Then we establish the integrity of the hiatus, and in addition we attempt to produce a normal esophago-gastric angle, reduce gastric acidity, and facilitate gastric emptying time, thereby reducing intragastric pressure (Figure 3).

The reasons for the abdominal approach, the experimental background and the technics employed have been referred to in previous publications and will not be repeated here.[1,2,3,4,6] However, the approach per se is unimportant if the disease is corrected and normal physiology restored. We use the thoracic approach occasionally in very old people who are obese and have long-standing, monstrous hiatal hernias. Under these circumstances reduction alone relieves symptoms.

Most patients operated upon had been on medical management for long periods ranging from two to 15 years.[6] The only exceptions were those who were bleeding, vomiting, or who had excruciating pain with partial obstruction. In a few instances emergency operations were done because of

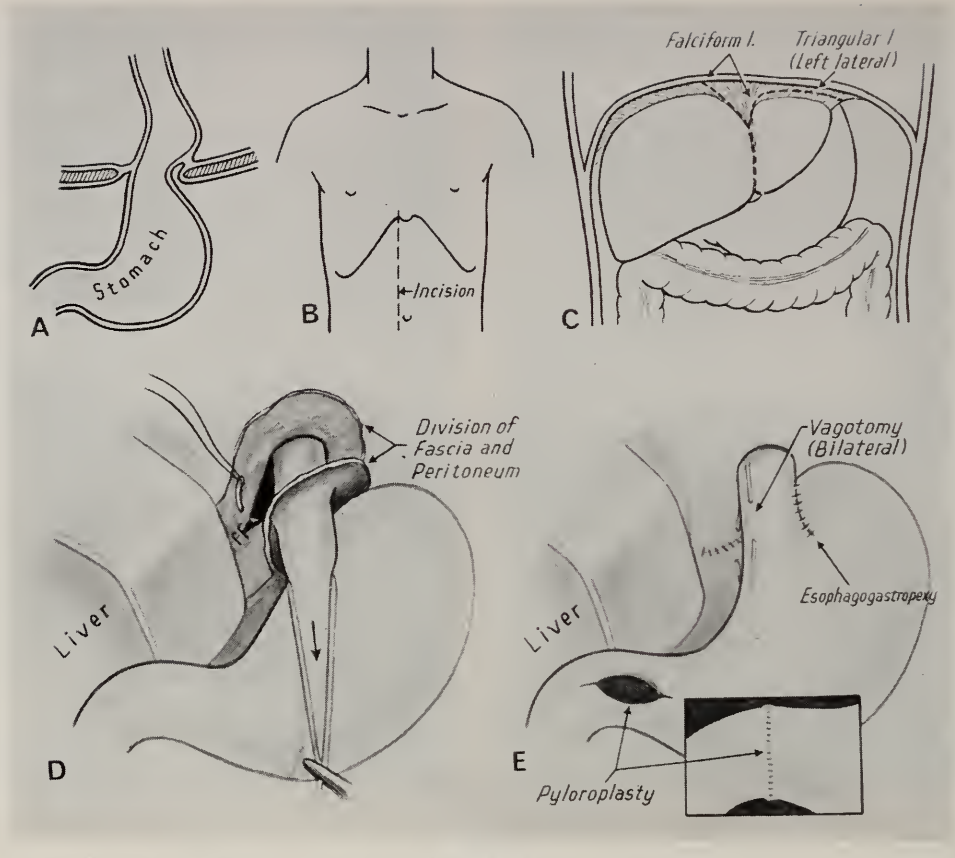


FIGURE 3

(A) DIAGRAM OF SLIDING type esophageal hiatal hernia. Note the loss of the esophago-gastric angle. (B) Right paramedian incision. In obese (lateral type) patients a bilateral subcostal incision may be used if desired. (C) The left triangular (left lateral) and falciform ligaments are divided and the liver retracted to the right. (D) The peritoneum and phreno-esophageal fascia are divided and the esophagus surrounded with a Penrose drain. The stomach is then pulled caudally; bilateral vagotomy is done. This increases the length of abdominal esophagus greatly. The right crus is repaired. (E) The completed operation showing repair of the crus, bilateral vagotomy, esophagogastropexy (to restore the angle of His or esophago-gastric angle) and pyloroplasty.

exsanguinating hemorrhage.

Postoperative Complications

Esophageal dilatations were done on many patients prior to operation. Sixteen were reported as being very tight, yet only two of these patients required cardioplasty (not cardiomyomotomy-Heller) in addition to the balanced procedure. Therefore we have concluded that in most instances if the reflux is controlled, the stenosis (which is partially due to edema and inflammatory reaction) will subside. All complications are listed in Table III. Most have been transient and easily controlled without further operative procedures.

Conclusions

1. Any type and size of hiatal hernia may give symptoms which are refractory to medical management. These should be alleviated by surgery.

2. Hiatal hernia complex is due to many factors, and the diaphragmatic defect may well be of ancillary importance. This is substantiated by the fact that a significant number of patients with esophagitis had no demonstrable hiatal hernia on fluoroscopic or x-ray examination.

3. These findings suggest the term "hiatal hernia complex."

4. The indications for surgery have been enumerated, but recent experiences have made us more aggressive and cautious. Patients not operated upon should have repeated fluoroscopic and x-ray examinations.

5. If surgery is indicated, operations must be balanced so that there will be:

(a) A return of the stomach and the esophagus to a normal position (Factors D, T, a and [e]).

(b) Repair of the esophageal hiatus (Factor b).

POSTOPERATIVE COMPLICATIONS IN 300 CONSECUTIVE PATIENTS HAVING THE BALANCED PROCEDURE FOR HIATAL HERNIA COMPLEX

COMPLICATION	NUMBER	PERCENT	RESULT
Immediate postoperative distention	15	5.0%	Transient; treated with Ilopan*
Diarrhea	7	2.3	Controlled with Normacid** and Lomotil***, one patient with gastric resection, five-six stools
Transient substernal pain without demonstrable recurrence or esophagitis, probably due to overcorrection of hernia	5	1.7	All relieved three-six mos.
Recurrence of stenosis in cases of mega-and dolechoesophagus	4	1.3	Treated with dilatations for about six mos., now free of symptoms but dilatations continued periodically
Dumping syndrome	3	1.0	Relieved by frequent feedings, except in one instance
Hepatic insufficiency in nutritional cirrhosis with bleeding varices	3	1.0	One died; two recovered
Wound infection and recurrence of hernia without symptoms	2	0.6	Re-operation refused
Coronary occlusion	2	0.6	Died
Recurrence of hiatal hernia with symptoms	1	0.3	Re-operation with good results
Incisional hernia	1	0.3	Repair; result excellent
Acute gastric dilatation	1	0.3	Transient; naso-gastric tube and Ilopan*

TABLE III

*Ilopan — d-pantothenyl alcohol
**Normacid — betaine Hcl (440 mg.) and pepsin (32 mg. dilution 1:10,000)
***Lomotil — brand of diphenoxylate Hcl and atropine sulfate

(c) A restoration of the normal esophago-gastric angle or even an exaggeration of this angle (angle of His) (plica cardia) by esophagogastropexy (Factor c).

(d) A reduction in the amount and the acidity of gastric juice by vagotomy (Factors D and T).

(e) A widely open pylorus to allow a ready egress of gastric contents, thereby relieving intragastric pressure by pyloroplasty (Factor d). This also permits exploration of the interior of stomach and duodenum.

6. With this procedure we have obtained uniformly good results. Most patients have been followed from one to 14 years.

7. Complications have been few and for the most part transient.

8. If symptomless hiatal hernia is present and unrelated surgery is required for other reasons, the hernia should be repaired and a "balanced procedure" performed.

Addendum

The total number of patients who have

had the "balanced procedure" for hiatal hernia complex is now approximately 400. Results in general have been excellent. However, we have learned that one of our patients developed gallstones four years after his operation; another with severe stenosis and dolechoesophagus still requires routine dilatations; and one with complete esophageal occlusion, for which cardioplasty was required, continues to have symptoms in spite of repeated dilatations. This patient may ultimately need a colon-replacement operation because of extensive scarring in the esophagus.

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About Our Cover

The time has not yet come when we are able to cure or prevent multiple sclerosis, leukemia or diabetes mellitus. But the prevention of tetanus has been a reality for many years.

In World War II tetanus was practically nonexistent in U.S. Army casualties, since all members of the Armed Forces had been immunized upon entering service.

Unfortunately today it appears that too many people neglect to have themselves immunized, or else fail to keep up their immunity by regular booster shots.

The forthcoming summer months, when children and adults spend much time outdoors, often barefoot, is the time when accidents are likely to occur that may cause wounds that can become infected with Clostridium tetani.

Why don't you make it regular practice to check the date of the last TAT booster with all your patients, both old and new. Stress to them the importance of this preventive measure both for themselves and all the members of their family.

This old adage may be corny, but it is so true: "An ounce of prevention is worth a pound of cure" . . . and with tetanus the cure is not alway certain!—M.E.R.

Tetanus Prophylaxis
(Changing Concepts)

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THE PREVENTION of clinical tetanus is one of the most gratifying preventive measures available to the medical profession. It encompasses two phases: (1) Preclusion of the growth of the causative organism, Clostridium tetani, and the concomitant liberation of its lethal neurotoxin; and (2) neutralization of the liberated toxin by either the patient's actively produced antitoxin or passively by administered antitoxin.

Although certain concepts regarding tetanus prophylaxis have become generally accepted, there is lack of agreement upon some aspects. It is our purpose to review these concepts in order to reinforce some presently established methods and to modify previously held opinions of other facets of this problem in the light of recent information.

Local Wound Care

The physician's first consideration should be adequate local wound care. The causative organism is a fastidious one requiring necrotic tissue and rather strict anaerobic conditions for growth and subsequent liberation of toxin. Hence the most important aspect of local wound care is careful, thorough debridement. The wound should be widely opened at skin level to permit adequate exploration of the deeper tissues. All necrotic and ischemic tissue should be removed. The possibility of a retained foreign body should be considered and eliminated.

If this vital first step is adequately performed early, the source of tetanus toxin will be eliminated. When debridement is incomplete, tetanus may occur immediately or tetanus organisms may remain in the healed original wound only to be reactivated later by trauma.

Manipulation of old fractures or excision of chronic ulcers several years after the original difficulty have been reported as the cause of clinical tetanus. Cultures of foreign bodies inadvertently allowed to remain in the original wounds have been demonstrated to yield viable organisms many years later. This special type of tetanus was recognized during World War I and was called cryptogenic or delayed tetanus. In such cases the tetanus spores present in the tissues could not vegetate and multiply as surrounding tissues were "healthy."

When later trauma or surgery resulted in devitalized tissue or blood clots, the spores vegetated, multiplied and caused clinical tetanus.[1] These facts furnish further proof that adequate local wound care is vital in the overall program of tetanus prophylaxis. *The administration of tetanus toxoid or tetanus antitoxin is not a substitute for adequate local wound care.*

Active Immunization

After the wound has been treated, neutralization of toxin should be considered. Although many patients have had the basic immunization, they often have failed to secure the recommended tetanus booster immunizations. These patients are typically young adults with no immunization since childhood, veterans without immunization since release from the armed forces or patients who received immunization at the time of a previous injury or at the time of employment. When they are injured, the problem of whether their immunity can be

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regained by toxoid booster immunization arises and, if so, whether the antibody response will develop quickly enough to protect them.

This problem has been partially resolved by Schlegal and by Turner, Stafford and Goldman.[2,3] They found, in separate studies, that patients retained their sensitivity and responded to booster immunization after periods as long as 11 years. The response in their series was found to be slightly delayed when compared with the response of patients who had received booster immunizations at two to three year intervals following the primary immunization.

Since many patients have not secured boosters for periods well over 11 years, we recently undertook the determination of the anamnestic responses of 51 individuals who had not obtained a toxoid immunization for from 14 to 19 years.[4]

Before the booster administration 84% of the patients were found to have antiserum levels thought appropriate for protection (0.01 unit per ml. or higher). By the seventh day after toxoid administration, 98% had achieved this titer or higher. By the tenth day all patients had reached or surpassed this level. The patients with low initial titers responded slightly slower than those with higher titers.[4] However, even those with low initial titers did attain 0.01 unit/ml. or more in a reasonably short time. Neither the route of administration (subcutaneous or intramuscular), nor the age of the patient significantly altered the response.

Passive Immunization

If the patient has not had previous active immunization, the most commonly used alternative is the administration of equine antiserum. This is associated with a significant incidence of allergic reaction and serum sickness. After careful study, Toogood found that the probability of a severe incapacitating reaction to tetanus antitoxin was approximately 200 times as great as that of developing clinical tetanus.[5] Although no accurate mortality statistics were available, he estimated the total number of deaths due to allergic reactions from tetanus antitoxin would approach that of tetanus itself.

These reactions may take the form of an immediate serum reaction such as anaphylactic shock; the more delayed serum sickness, the incidence of which increases with larger doses of foreign protein; and the rarer but more serious complications such as periarteritis nodosa, myocarditis, pericarditis, myelitis or neuritis. To a limited extent, sensitivity testing has been helpful in screening and eliminating those individuals who are already sensitized and most likely to have reactions, but it has not completely solved this problem. Purification of the antitoxin has permitted the use of larger doses without a corresponding increase in serum sickness.

Even though an individual found to be allergic by skin test can be "desensitized" and the desired dose of tetanus antitoxin given, his circulating antitoxin decreases more rapidly than in the non-sensitive person. A second injection of antitoxin in these patients is relatively ineffective and gives an adequate blood level for only a brief period.

In the past, bovine antitoxin has been used in those patients allergic to horse serum and not sensitive to bovine. Unfortunately, many are also sensitive to bovine antitoxin. In addition, the administration of bovine antitoxin, usually accompanied by a greater quantity of foreign protein, may lead to a higher incidence of serum sickness.

Homologous Antitoxin Now Available

Recently human tetanus immune globulin has become available. It has the following advantages: (1) There is a low incidence of reactions. Those that do occur are in individuals sensitive to gamma globulin; (2) The administration of fewer antitoxin units results in higher circulating levels than similar amounts of equine antitoxin; (3) There is less individual variation in circulating levels for similar doses; (4) It is eliminated more slowly thus maintaining levels for longer periods. The major disadvantage of human tetanus immune globulin is its high cost.

Although the number of antitoxin units necessary for passive prophylaxis cannot be directly established, it can be reasonably inferred from previous experience with other

methods of tetanus immunization. Most agree that a circulating level of 0.01 unit per milliliter of actively produced homologous circulating antitoxin will protect the patient against clinical tetanus. It has not been definitely established whether the circulating antitoxin alone is the important factor or whether circulating antitoxin plus tissue reserve in the actively immunized individual is most important. Ipsen has shown the appearance of an increased immunity in actively immunized rabbits before circulating antitoxin is detectable.[7]

In those individuals who are passively immunized with equine tetanus antitoxin, a circulating level of 0.1 unit per milliliter has been considered protective.[3] This is the titer that usually follows the administration of 1500 units of equine tetanus antitoxin. Due to the more rapid elimination of this product, this level is not maintained. This is one of the considerations that has led many to recommend 3,000 to 5,000 units as a more efficacious dose.

There is the additional consideration that homologous antitoxin is more effective than heterologous antitoxin even though the circulating levels are the same. This increase in effectiveness has been estimated from tenfold to as much as a hundredfold. Rubbo and Suri estimated that a circulating titer of .05 units per milliliter following the administration of homologous antitoxin would be protective.[6] This level was maintained in nine patients for 14 days following the administration of five units/Kg. of body weight or approximately 350 units total dose for the average adult. They concluded, after consideration of individual variation and slight deterioration in storage, that the recommended dose should be 400 units of human tetanus immune globulin for the average adult and 200 units for the average child.

McComb and Dwyer thought that 250 units of human tetanus immune globulin would offer man at least the same margin of safety as the 1,500 unit dose of equine antitoxin.[8] Following the administration of this dose of human immune globulin to 16 patients, they found titers of at least 0.01 antitoxin units/ml. in all patients for at least 28 days. In 15 of the patients, they had administered an initial toxoid injection at another site of the body on the same day.

Antibiotic Therapy

Antibiotic prophylaxis has been used in some individuals who were found to be sensitive both to equine and bovine antitoxin. To be effective, it must be started within one to two hours after injury and relatively large doses should be used (tetracycline 500 mg. every eight hours or five million units of penicillin per day) for at least seven days.[9] Antibiotic therapy may also be considered to supplement active or passive immunization in selected cases. It should be considered as replacement only on very rare occasions.

Summary

Local wound care remains the most important consideration in the prevention of clinical tetanus. Since even small wounds may lead to tetanus, the possibility should be considered and the wound treated accordingly. All wounds should be opened widely enough and explored to eliminate the possibility of a retained foreign body or necrotic tissue.

There is little doubt of the superiority of active tetanus immunization utilizing toxoid. Patients whose latest immunizations were as long as 19 years ago can be boosted effectively, although the recommended booster interval should be shorter. It should be recommended not only to prevent tetanus, but also to eliminate the need for horse serum with its accompanying reactions.

If, following an injury, tetanus prophylaxis is advisable in a previous unimmunized individual, then administration of equine tetanus antitoxin should be considered. The cost and short supply of human tetanus immune globulin will, for the time being, restrict its use to those patients who are sensitive to heterologous antitoxin.

On the basis of present information, it would seem that 250 units of human tetanus immune globulin will be at least as protective as 1,500 units of equine antitoxin, although 500 units may be advisable for more severe injuries. With the accumulation of further information, it may be possible to reduce these doses.

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The Miracles of Chemistry

. . . Chemistry, if I may so speak, is one of the creations of this age. It is one of its active, scientific and all-prevading powers, and it must be classed among the grand and lofty results of the philosophical analysis of the present age. We can form no estimate of our indebtedness to its analytic powers for the development of our extended therapia. How greatly has it strenghtened our armory by its explorations of the exterior elements of a large class of essential remedies, so that we may now in our everyday practice realize, in all its fullness, efficiency and power, the grand but long-ridiculed idea of Paracelsus, that medicines would in time be given in their quintessences. Chemistry not only separates the peculiar elements of medicinal substances, but exhibits their varied qualities, and reveals the law of their relations, thereby furnishing medical men of this age means for defense against disease, and power to combat it in all its varieties and insidious forms, in all climates, for which antiquity with its knowledge and civilization, had no remedy. What agencies have been brought out of mercury, opium, and bark? Look for a moment at the catalogue of diseases that have been measurably disarmed of their terrors by these agencies. Syphillis[sic], tetanus, pestilential or pernicious malarious, constitute their types. Chloroform is a remedy that in this age marks our literature through the power of chemistry, by its influences in rendering the system insensible to pain and by producing calmness and serenity under the most terrible operations of surgery. To woman, suffering woman, it is the millennial elixir.—E. Deming, M.D., "Address of the President before the Indiana State Medical Society," May, 1854.

The Case of Doom Beyond Damnation

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WHAT DUNGEONS immure which souls beneath the bottomless pit of Dante's inferno? The brain pounded by hammering microsecond pulses of electron clouds: the neuron potentials oscillating relentlessly from plus to minus and back. The magnified tortures of Tantalus; the incessant pain wracking every waking moment! How did this bedeviled being cling to life through all the anguished years? What crimes unutterable had this wretch committed that God had denied his soul the peace of death?

Tossing these theological tortuosities aside, let us reconstruct the record as it was written. Dick Dan—as good a name as any—came to the emergency room of our hospital at 3:30 a.m. on a grey Sunday morning. "Unknown, unconscious, white male": a dreary, all too common admitting entry of totally obscuring anonymity. The policeman had stumbled over the prostrate, alcohol reeking, lice infested, inert form. Not succeeding in kicking the derelict awake, he called an ambulance. The minion of the law dumped the vile vagrant into our laps and departed in all haste.

The night intern grumbled at being forced to fumble through such filth before he could listen to the heart and lungs. Having to bring his nose close to such an excremental stench did nothing to sweeten his temper. The orderly had to peel off the remnants of adhering rags; the body was soused with Septisol and a gown tossed over the exposed wretch. An intravenous

Author's note:
Resemblance to any person, living or dead, is purely coincidental.



The police had called an ambulance.

was started and the cart wheeled up to the medical ward. There, the resident noted the deeply stuporous patient, moaning and scratching himself; numerous lice were still present.

The doctor recorded also the presence of scabies; the reddish tunnels with the vesicular swellings containing the Sarcoptes scabiei were visible almost everywhere. The skin of the poor, crowded, unwashed masses is a particularly prolific breeding surface for these parasites. They cause a ferocious, all but unbearable itching. The mange mites of canines can also invade the human skin —now-a-days, this clinical fact tends to be forgotten.

In his further survey, the doctor noted also a blood pressure of barely 70/?; pulse —120, fluctuatingly irregular; temperature —only 96°F. The eyes were covered with a greyish, purulent exudate; the pupils were dilated but equal and regular, reacting slightly to light. Both ear canals were clogged shut with wax. The mouth had puffy, distorted lips crusted with exudates and bleeding. Unexpectedly, the teeth were still present. The tongue was swollen and protruding, the mucous membranes pale and parched dry. The neck showed no venous engorgement and was supple. There were vesicular rales throughout the chest. The heart tones were faint and somewhat irregular; no murmurs were heard.

The abdomen appeared to be somewhat distended with ascitic fluid; occasional audible bowel sounds were heard; there was no rigidity. The external genitalia showed the innumerable lice, itch mites and crusted excoriations previously noted. The swollen phallus was recorded as being of extraordinary size. Spontaneous motor activity was present in all extremities being most marked in the hands; no response to painful stimuli could be elicited. The diagnoses were made of (1) chronic and acute alcoholism with impending delirium tremens (2) marked dermatitis secondary to lice and scabies (3) extreme malnutrition and dehydration (4) endotoxic shock to be ruled out. As can be seen, the examination had been meticulously systematic and thorough.

A Delirious Derelict

Among my numerous faults is the habit of making ward rounds at dawn. Around six a.m., I walked in to find my young associate busy with laboratory work being done at the bedside. Without these studies being interrupted, the emergency room outfit was called; they grumbled, but they really cleaned our derelict up. He was disinfected, scrubbed as well as possible and then moved to another bed. The linens in which he had lain overnight were rolled up and carefully bundled for separate sterilization.

The hemoglobin was below 9 gm.; the hematocrit reading—28%; blood glucose—220, urea nitrogen—30, sodium—138, potassium—3.4, chlorides—113. Total blood proteins were 6.2 with an A/G ration of 3.3/2.9. The direct van den Bergh was 3.0, the indirect 1.4; alkaline phosphatase—4.0. Prothrombin time was 22/13. The urine had a specific gravity of 1.019, albumin three plus, no sugar present, a few red blood cells and white blood cells were seen.

The patient had type A, Rh positive blood so that fluid was obtained and crossmatched before being poured in. The white blood count was phoned up by the technician as: 23,000 with extreme shift to left.

An x-ray of the chest showed only haziness throughout the lung fields; the cardiac silhouette was somewhat above normal. A flat plate of the abdomen did not surprise us with the left midportion demonstrating the "sentinel loop" suggesting a localized paralytic ileus of the jejunum. The "colon cut-off" sign was not seen. The E.K.G. showed some postero-lateral ischemia which, in view of the dehydration and incipient shock state, was not astonishing.

While all this activity was going on, I commended the resident for his remark anent "endotoxic shock to be ruled out." The odor of the breath had that repulsive stench so suggestive of a fresh cadaver: the amine odor of fetor hepaticus. The grossly irregular, flexion-extension movements of the hands and outstretched arms combined with the constantly dorsi-flexed feet and protruding tongue are almost diagnostic in themselves of ASTERIXIS, the flapping tremor of *hepatic coma.* We got the ankle clonus but failed to elicit positive Babinski signs.

Of course, in an unconscious, moribund patient, there is some difficulty in differentiating this far graver entity from the ordinary, all too well known, delirium tremens. I suggested to the resident that he look up the more recent theory that asserts hepatico-renal coma to be a sort of "biochemical decerebration", i.e., alpha ketoglutaric acid unites with NH_3 forming glutamic acid: this effectively blocks the vital citric acid cycle. In our patient, we could assume long-standing alcoholism. Repeated bouts of pancreatitis could be taken for granted*

The anemia could be on the basis of malnutrition. Also, it could be on the basis of esophageal varices, gastric erosions and not to be forgotten peptic ulcers as yet undemonstrated but likely to be present. After all, advanced liver cirrhosis of the Laennec variety also had to be there.

Basically, all this pseudo-profound perorating was really an exercise in futility. The now partially cleansed but still repulsive ruin was in extremis. On the chart, I see my jotted note, "Severe emaciation, d.t.'s in past; he *must* have a liver damaged beyond repair plus bleeding esophageal varices, gastrointestinal erosions (if not ulcers) and the entire book. Pouring in blood, supportive therapy, etc. is indicated even if only as a gesture . . . nearly past any help."

From the Peak to the Pit

In the same morning but at the more decent hour of about ten o'clock,—there arrived the attending physician charged with the supervision of this particular ward during that month. He recognized the "unknown white male" immediately!! "Why, this is Dick Dan! I've known him for many years; used to be a splendid chap! Owned a big name shop on Fifth Avenue; lovely wife; fine family; respectable church goer and all that! And then he skidded to Hell: literally! Wine and women; a really incredible, fantastic, boudoir athlete! Day and night and never satisfied! And ALCOHOL! My God; he could and would swill a bar dry all by himself! His wife left him; he has had three others since then, plus 3,000 odd women on the side. No! I never was his doctor but I still know his first wife. I'll have to call her; she still sighs for the husband she knew; women are funny, you know! But that is how it is!" Shaking his head, he went to the phone.

This unbelievable coincidence confirmed many of our suspicions but it also raised many questions. Dick Dan *looked* past 70 but chronologically was a mere 45. AND: what changed Dr. Jekyll to Mr. Hyde.

Be our speculations what they were, we all did our best. Five pints of blood went into Dick Dan's veins during that day and night. Stimulants, other fluids, vitamin K, Neomycin, calcium gluconate, magnesium sulfate, Lipomul, etc. ad infinitum. The first wife materialized before sundown. She was

*The exact mechanism of alcohol induced pancreatitis is not known. Clinically, the most common reason for this disease is excessive alcohol intake; biliary obstruction accounts for the bulk of the other. The physical factor of edema leading to pancreatic obstruction is accepted as the cause for the reflux of pancreatic juice. The alcohol stimulates the acid-secretin cycle while, simultaneously, producing the duct blocking edema. There is another possible rationale: the excess of ethyl radicals may affect, competitively, methyl radical metabolism; this has been shown to cause severe pancreatic necrosis.

still very beautiful, a well-poised, pleasant woman in full maturity but not as yet showing the sag of middle age. With quiet efficiency, she went out to get some special nurses; I dissuaded her from attempting a move to a private hospital. She did not flinch from the patient moaning in his delirium; she did pale a bit when the wretch coughed up a good pint of coffee-ground vomitus mixed with brighter blood. Even as the nurses were cleaning up the mess, we talked a bit; by intervals, we built up quite an intime conversation: snatches of confidences long held back were now released as she stood or sat by the bed of the dying man.

For Dick Dan *was* dying. The temperature started to rise; respirations and pulse did pari passu. Congestive failure threatened, warning us against pushing in too much fluid too fast even as we were attempting to restore the dried out tissues with their awry electrolyte balance. The white blood count rose to 35,000 with an "extreme shift to left"; I'm ashamed to say that I failed to look at the hemotoxylin—eosin stained slide myself. In spite of all our efforts, the blood pressure hovered below shock levels. Even as I write now, I'm looking at the final note I had written on the chart: "This is a fantastic tale; a veritable plunge from Fifth Avenue to Lake Avernus! Why such damning degradation?"



She stood by the bed of the dying man.

Termination of Tribulation

Dick Dan did not survive past midnight. Before me is the autopsy permit signed by the wife he had abused so cruelly; she signed it with her present name. On the back of this form, the pathologist had scribbled the gross anatomical findings: (1) pulmonary edema and congestion (2) bleeding esophageal varices (3) advanced cirrhosis of the liver (4) chronic pancreatitis with pseudocysts (5) duodenal ulcer.

However bizarre and instructive as this tale may be, it does not rest on the written record alone. While the autopsy was just being started, the bright young resident observed the enormous phallus and remarked, smirkingly, "Most severe case of post-mortem edema down there that I've ever seen." And—with sudden clarity—I realized what had been distracting me in this case. My mind slipped back in time. I was a fresh, eager Cook County Hospital (Chicago) resident again. I had accompanied my chief to the morgue to be a witness of the autopsy on an unusual medico-legal case. A very distinguished scion of a famous family had gone berserk: he had attacked, raped AND then murdered a young girl. He had been taken to the psychopathic ward; the chief of the staff had been called in consultation. He had made the correct diagnosis; the criminal was mortally ill and he died soon thereafter. As we stood by the drab slab on which the body lay, a chap who did not know the diagnosis had wisecracked, "POST-MORTEM EDEMA down there is new to me!" The witty intern was crestfallen when apprised of the true state of affairs.*

In the 30-odd intervening years, that case had faded from my memory. The repetitive gibe had suddenly flicked the whole scene onto my mental screen! Of course! Why had I not thought of this before? While the pathology resident was busy with other things, I got the bone marrow needle and

* Lieberman, A.: *U. of Chicago Magazine*, March, 1933, Vol. xxv, No. 5, pp. 211-213.

2. Craver, L.F.: Priapism in Leukemia. *Surg. Clin. N. Am.* 13:472, April, 1933.

3. Ritz, N.D., Purfar, M.: Chronic Myeloid Leukemia with Priapism. *N. Y. State J. of Med.* Feb. 15, 1964, Vol. 64, No. 4, pp. 553-556.

aspirated the sternum. I made several slides; my efforts to retrieve the peripheral blood smears taken during life failed, as they had been discarded. But the smears I took post-mortem were revealing enough; they *had* to be! Dick Dan had had *myelogenous leukemia,* the adult, chronic variety.†

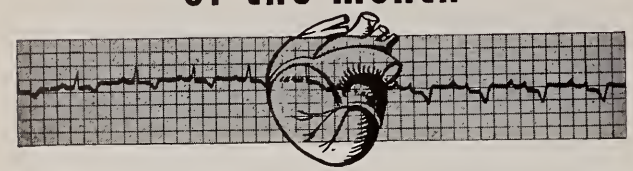
Cecil-Loeb (11th edition) says not a word anent *priapism* as a presenting symptom of leukemia. It *is* discussed in psychiatry texts. Thank God for the rarity of this terrifying and doom-damning complication! In a life span of rather active practice, I was seeing only my second case: and this was two too many! We are now back to my opening paragraph. What agonies must have been the constant companions of the uncomprehending, totally damned Dick Dan! No wonder he took to wearing the cod piece his wife had mentioned with such loathing and abhorrence during our bedside conversation. The Satanic satire of phallic prowess was merely the visible sign of excruciating priapism! The eternal erection no more to be quenched by carnal contact than Greek fire could be extinguished by water! Paralyzing pulses of penile pain unimaginable and inconceivable! No wonder that this sacrifice to Priapus sought oblivion in stupefying oceans of alcohol! Sodden stupor gave some surcease to the throbbing horror!

I made inquiries re Dick Dan's medical history. No doctor had looked at the slides read by technicians. The white blood counts had been read as "high counts"; nothing more appears on any record. What right have I to be a Paul Pry? There could be sticky medico-legal problems. I did look with some curiosity at the final findings made by the pathologists. The detailed analysis covered many things of importance even as it concealed the really vital facts; it was meticulously precise—but *so* silent about matters of which it was and will remain completely ignorant. It is just as well. ◄

1270 Fifth Ave.
New York, N.Y.

† Leukemias are, at present, diseases of unknown origin. They are a form of neoplastic proliferation. Nobel Prizes are in the process of being earned by pioneer workers who are demonstrating that, in all probability, viruses are one of the causative elements producing the wild mutation. INFECTIVE HEREDITY is the term, which it is hard to become accustomed to. It implies the addition, infectively, of virus nucleic acids which insinuate themselves into the hereditary mechanism. Clinically, however, we have the rather clear-cut picture of the disease classified by the type of cell and rapidity of progress. We have: *acute* leukemia seen usually in children. It can be lymphocytic, myelocytic or monocytic. Regardless of the type, it tends to progress rather rapidly to its lethal ending. The *chronic* leukemias run a slower course; they are the so-called adult type. Patients early in the disease may seem quite healthy, the true condition being discovered by a blood smear examination made for other reasons. Anorexia, weight loss and weakness develop gradually. Hepatosplenomegaly may become massive and lymph node enlargements give rise to pressure symptoms. As of today, many and varied methods of chemotherapy are being studied as adjuncts to the standard irradiation, blood transfusions, supportive measures, etc. Not long ago, I had a patient die *22* years after the original, well-proven diagnosis of chronic myelogenous leukemia.

Electrocardiogram of the month



Presented as a regular feature of The JOURNAL, Electrocardiogram of the Month is a series of short talks on cardiovascular diagnosis and treatment, edited by the staff of the Krannert Heart Research Institute, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis.

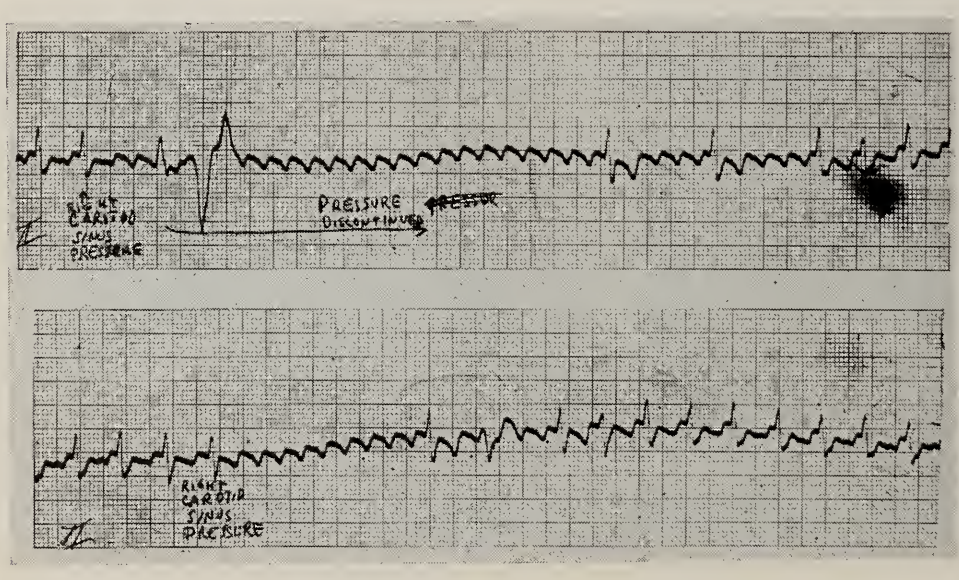
Atrial Flutter

CHARLES FISCH, M.D.
Indianapolis

THE DIFFERENTIAL DIAGNOSIS of supraventricular tachycardias (sinus tachycardia, atrial tachycardia, flutter and fibrillation) may at times be extremely difficult. Compression of the carotid sinus, via its vagal effect, increases atrioventricular conduction and at times results in a higher degree of A-V block. This procedure is most useful in cases of atrial flutter.

Compression of the carotid sinus in such instances exaggerates the degree of A-V block. Release of the carotid pressure results in prompt reversion to control degree of block. Such an example is shown in Figure 1.

The upper strip shows a classical atrial flutter with the saw tooth appearance of the baseline, an atrial flutter rate of 300 and a 2:1 response. With pressure of the right carotid the degree of block increased. When the pressure was discontinued, the block returned to 2:1 atrioventricular response. A similar response is recorded in the bottom strip.



ATRIAL FLUTTER with increased A-V block as a result of right carotid sinus pressure.

X-RAY CONFERENCE

Presented as a regular feature of *The Journal*, X-ray Conference is a series of short talks on procedure and radiologic diagnosis, edited by Erich K. Lang, M.D.

Lateral Meningomyelocele

*JOHN RUSSELL, M.D.**
*CHARLES CURE, M.D.**
*ERICH K. LANG, M.D.***
Indianapolis

A CHEST FILM occasioned by an "executive type" of physical examination revealed a mass in the left lower lung field in this 51-year-old white male (Figure 1). The patient had no particular symptoms or complaints referable to such a mass. The last chest survey film had been obtained some 20 years ago during a discharge physical examination from the United States Navy. This film was apparently interpreted as negative.

A careful physical and neurological examination failed to reveal any significant abnormalities with the exception of a questionable Babinski sign on the right side. No other long tract signs could be elicited.

Because of the posterior position of this mass, the possibility of a neurogenic tumor or a lateral meningomyelocele was considered.

Roentgenograms of the dorsal spine revealed a typical pressure erosion of the posterior circumference of the bodies of D9, D10, and D11. However, there was no particular widening or erosion of the intervertebral foramina such as one might expect with any "dumbbell" tumor originating from the neural canal. Likewise, the classical roentgenological feature of splaying of the pleural deflection seen with swanomas was not present. Furthermore, the complete neurologic quiescence of this mass

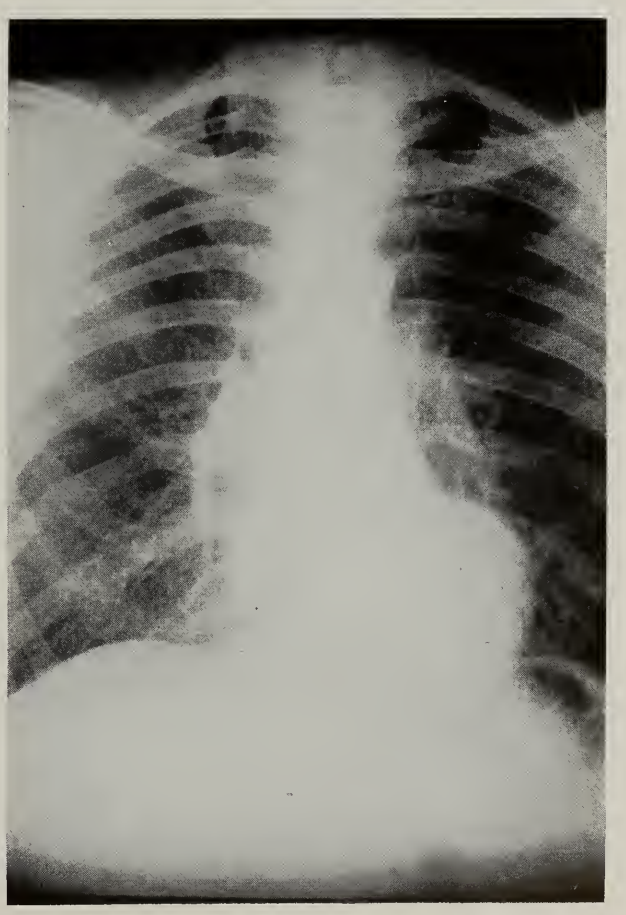


FIGURE 1

THE CHEST ROENTGENOGRAM reveals a huge mass presenting behind the heart shadow in the left lower hemithorax. A classical silhouette sign is demonstrated defining the mass as a posterior one.

* 1815 N. Capitol.
**Radiologist, Methodist Hospital.

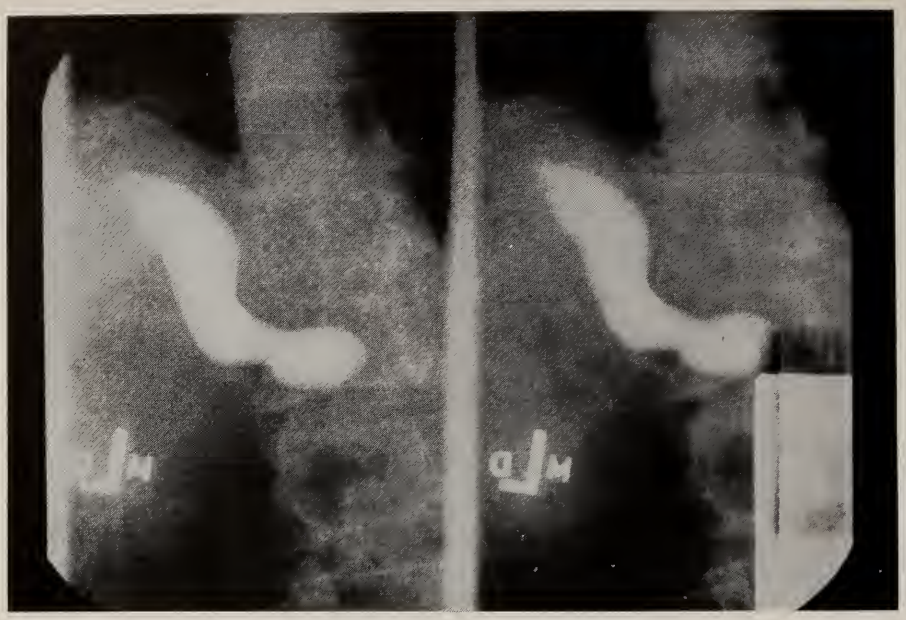


FIGURE II
THE PANTOPAQUE is seen to enter the huge meningomyelocele through its relatively narrow neck at the level of D11-D12.

mitigated against a significant space occupying component in the intrathoracic canal. A lateral meningomyelocele appeared to be an excellent possibility both on the basis of the roentgenographic appearance of the mass as well as on grounds of its neurologic quiescence.

A myelogram was performed. Nine cc. of Pantopaque were introduced into the lumbar canal. In 30° cephalid tilt, the meningomyelocele filled readily with Pantopaque through a narrow neck communicating with the intrathoracic canal at the level of D11 (Figure 2). The Pantopaque droplets would cascade into the huge sac and move around completely freely. Caudate tilt of approximately 20° would readily empty the Pantopaque into the neural canal. Cineroentgenograms, in particular, showed the communication and free motility of Pantopaque to and from the huge meningomyelocele.

Discussion

Lateral meningomyeloceles, while relatively rare, have received increasing attention in the recent literature. They are invariably asymptomatic and are usually discovered on routine chest surveys. Their ominous roentgenographic appearance will often suggest a bronchogenic carcinoma or neural tumor to the untrained observer. However, the correct diagnosis is usually suggested by the characteristic erosion of the posterior circumferences of the bodies, with absence of any erosion of the intervertebral foramina and the characteristic neurologic quiescence. The diagnosis is readily verified by myelographic demonstration of a communication between this mass and the neural canal. ◄

LABORATORY MEDICINE

This page reviews established or relatively new but reliable laboratory procedures for physicians in general. It is not designed for specialists and laboratory personnel who would desire more technical information.

Laboratory Automation*

WEI-PING LOH, M.D.†
Gary

Electronic Cell Counters

A. *Coulter Counter* (*Coulter Electronics, Hialeah, Fla.*) This instrument is built on the principle that blood cells are poor electrical conductors, as compared with a saline solution in which the blood cells are suspended. When a blood cell is sucked to pass through a small aperture between two electrodes, there is a transient voltage drop which creates a voltage pulse. The pulse is then amplified and recorded on a high-speed electronic counter and can be visualized by means of an oscilloscope. A built-in mercury siphon sucks 0.5 ml. of cell suspension through the small aperture for each count and the reading recorded on the counter can be readily converted into the number of cells per cmm. The machine has a threshold setting which allows one to count cells or particles larger than a predetermined size. In order to function properly the instrument has to be well calibrated and excellently maintained. The important advantages of the instrument are as follows:

1. High speed. The instrument takes 25 seconds per electronic count in contrast to three to five minutes per technician's visual blood cell count. The productivity can thus be increased 10 to 20 times.

2. High degree of accuracy. When properly used, the instrument can count red cells to within three percent error in contrast to 11 to 22% error for visual counting. No addition or multiplication is needed. Opportunities for human error are much reduced.

3. Many uses. In addition to red cell and white cell counts, the instrument can determine red cell volume, size of the red cell population, bacteria count, spermatozoa count and platelet count (not yet perfected).

B. *Other cell counters.* Several other electronic counters are available to challenge the Coulter Counter's pre-eminence. They have not been fully evaluated as to their performance.

Electrophoresis and Chromatography

Automated electrophoresis has been accomplished by means of the density gradient principle and a modification of the Autoanalyzer. The serum samples are picked up from a rotating Autoanalyzer sampler plate and pass through a cell containing sucrose at varying densities. As a sample moves through the gradient, a current is applied and separation results. The various peaks are scanned by ultraviolet light at 280 mu and the resulting pattern is traced on a stepchart recorder.

With this new technic it is possible to obtain the electrophoresis results in 20

* Part II, continued from April.

† Chief Pathologist, Methodist Hospital of Gary; Assistant Professor of Pathology, Chicago Medical School.

minutes instead of 18 hours which might be required in the old technic. As many as 72 serum samples can be analyzed at one time. Automation has also been highly developed in column chromatography, especially for separation of amino acids in biological material, steroids in urine and fatty acids in blood. Automation is being developed in the newer gas-liquid chromatography which will be discussed at a later date.

Semiautomatic Instruments

The semiautomatic instruments applicable to clinical laboratory use include chloride titrator, prothrombin machine, flame photometer, fluorometer, autodiluter, automatic pipette and many others. In these instruments some phases of the procedure are automated, although manipulation by a technologist is needed to complete or initiate the analysis. Automation has contributed much to standardizing the pipetting, centrifugation, weighing, mixing, recording and other important phases where human errors may occur in the laboratory procedures. ◄

Bright Future in Mental Disease Prevention

The keys to the rapid progress we are making in the management of emotional disturbances are the new drugs and the treatment technics which are at our disposal. We now measure treatment in terms of days, weeks, or months instead of years and decades.

These medical advances also mean that the psychiatrist no longer stands alone—all physicians, regardless of specialty, have tools and knowledge enough to diagnose and manage many forms of mental illness. Nor have we yet really touched prevention's great potiential.—Millard B. Bethel, M.D., in *Hawaii Medical Journal,* January-February, 1964.

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

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Federal Law Prohibits Dispensing Without Prescription

THE ABOVE PHRASE is a "Caution Label" appearing on the containers of all drugs classified as not safe for self-medication. It is known as the Rx Legend. It signifies that the drug is potent enough to require the judgment of a licensed practitioner to validate its use by the patient and to determine its dosage, the frequency of administration, the length of time it is to be used and the advisability of repeated administration.

In addition to requiring that the original dispensation be dependent upon a practitioner's prescription, the Rx Legend indicates that the drug cannot be obtained upon the same prescription unless there are specific instructions from the practitioner to govern refilling the order.

As drugs become more potent and as more and more drugs are characterized by occasional side effects or toxic effects, the Rx Legend becomes more important and the responsibilities involved in the dispensing of Rx Legend drugs become greater. Federal laws governing the use of drugs have been strengthened from time to time, and the Food and Drug Administration has increased its vigilance as drugs have become more potent.

The pharmacist is the legal custodian of such drugs. It is the pharmacist to whom the prohibition of the Rx Legend applies. It is the pharmacist upon whom the law depends for compliance. However, since the pharmacist's professional activity involves the patient on one hand and the practitioner on the other, and since the business good will of the pharmacist depends upon amicable relations with both, the law actually applies to all three and the law looks to all three for compliance.

Patients sometimes embarrass their pharmacist by insisting upon Rx Legend drugs without a prescription, or without the doctor's approval of a refill. Physicians sometimes appear to resent calls from the pharmacist who seeks their approval of prescription refills. Both patients and physicians are to be reminded that the law and the pharmacist's actions in complying with it are designed for the good of the patient and the protection of the doctor.

Unless the original prescription bears specific instructions in regard to refilling, and except in the case of narcotic drugs, the pharmacist is duty bound to obtain a verbal

assent from the prescriber before refilling any Rx Legend prescription, or any prescription for a non-legend drug which has been prescribed in unusual dosage.

The custom of some prescribers to indicate refillability by writing "Refill P.R.N." or "Refill ad lib" is not recognized nor prohibited by the law or by regulations. Such wording, however, is not considered acceptable by most pharmacists and should never be used.

In the case of prescriptions in which the drug may be safely repeated, the physician should indicate his wishes as to refilling when the original prescription is written. It is best to indicate a definite number of approved refills. This will decrease the number of times the pharmacist will need to call him for instructions, since the pharmacist is required to call for approval only after the prescription has been refilled the number of times indicated when it was originally written.

In the case of prescriptions for drugs for which the safety of refillability cannot be determined when the original prescription was written, the physician should accept calls from the pharmacist without resentment and cooperate with the pharmacist in his duty to comply with the law and his desire to protect the patient.

AFL-CIO Studies Hospitals and Their Services

A study by the Community Service Committee of the AFL-CIO in regard to short-term general hospitals and hospital service has been published recently. The subject has apparently been studied carefully. The report is a well thought out document and, while some of its conclusions will not be agreed with by the medical profession, the main structure of the report is valid and interesting.

The introduction acknowledges the tremendous advances of medicine in general and hospital care in particular. The importance of good medical care for everyone is stressed. The concern of everyone for its accomplishment is pointed out.

Problems and difficulties are detailed as follows:

1. While recognizing the improvement in medical care, the need for new and expensive equipment, and the need for more personnel to effect the improvement, the report deplores the increase in cost. (Most of the increase in hospital costs is due to better pay and shorter hours. See #10 below; the AFL-CIO thinks the cost is too high but also thinks it should be higher.)

2. Hospitals are built without community planning in some instances, with the result that hospitals are *occasionally* the wrong type or size or are in the wrong location. (Emphasis supplied by us)

3. There are too many small hospitals. (Hospitals should be no larger than necessary to care for the area served. Some areas need small hospitals because they contain fewer patients.)

4. Despite the increase in short-term hospitals at great expense, there are serious deficiencies in facilities for long-term care.

5. Insufficient use is made of the diagnostic and treatment facilities of hospitals for ambulatory patients.

6. Health insurance is not broad enough in coverage and not enough people are covered. Health insurance is not organized to control quality of care. (Number 5 and 6 are to some extent contradictory. If health insurance companies require a hospital stay of 18 hours or longer before reimbursing the patient, they may be doing this to obtain a hospital record and a physician who has been screened for "quality" to some extent. More money could be saved by allowing insurance coverage for diagnostic and treatment procedures which are carried out at private medical offices.)

7. Not enough hospitals are accredited.

8. There is insufficient development of group practice.

9. Hospitals are not controlled and administered by the patients. Hospital insurance should be administered by the public. (Should unions be administered by the public?)

10. Despite the findings in numbers 1, 3, 4, 5, 6 and 7 above, the report emphasizes that hospital employees should be organized

and should be paid better wages.

11. Some hospitals discriminate against patients and staff doctors because of race or color. (So do some unions).

12. There is a failure to utilize the powers of government to remedy the deficiencies.

The recommendations of the report are:

1. Community planning or better community planning. (O.K. if what they want is true community planning.)

2. Control of hospitals costs by limiting the use of high cost facilities to those patients who absolutely require them and for only so long as is indicated. (Government figures indicate that patients with all or part of their hospital bill covered by insurance stay in the hospital on the average two days less than those without any coverage.)

3. Maintaining and promoting quality of care by encouraging accreditation, and by paying public funds to accredited institutions only.

4. Insurance plans to include all medical care provided by group practice. (Some physicians work best in a group, others work best and most efficiently in solo practice.)

5. Consumers to be represented by majority groups on boards of hospitals and health insurance companies. (No mention made here of having outsiders as the controlling majorities in labor organizations.)

6. Collective bargaining by hospital employees. (Apparently with the purpose of increasing wages and decreasing hospital costs.)

7. Abolition of racial discrimination (The reference here is Luke 6:42).

8. Legislative action to establish hospital planning, to require detailed reporting of hospital finances to the public, to license hospitals in such a way as to insure high quality of care, to provide for federal loans for the establishment of group practice plans and to provide for hospital and allied insurance for the aged.

9. Require that hospitals be reimbursed for the full cost of care in the case of welfare patients.

One of the concluding paragraphs of the report states: "In order to translate the preceding policies and recommendations into action, labor bodies and cooperating public-spirited groups need blueprints as well as goals. Many of the proposals regarding planning agencies, composition of governing bodies, specific provisions of legislation, etc., need to be worked out with expert advice from various sources, and to be flexible enough for adaptation to diverse local conditions. The AFL-CIO must give leadership in moving from ideas to realities."

AMA to Award Certificate of Merit to Ohio Doctor

THE AMERICAN MEDICAL ASSOCIATION will bestow a Certificate of Merit on Dr. Herbert Morris Platter, 95-year-old Columbus, Ohio, physician, at its San Francisco meeting for his role in promoting the first AMA Scientific Exhibit in 1899.

The certificate will be given to Dr. Platter at the second annual AMA Scientific Awards Banquet, Wednesday evening, June 24, which will be held in conjunction with the association's 113th annual meeting in San Francisco, June 21-25.

Dr. Platter was secretary of the Committee on Arrangements for the AMA meeting in Columbus, June 6-9, 1899. In that capacity, he secured space for the first AMA Scientific Exhibit. More than 700 pathologic specimens were shown.

He acted on the appeal of many AMA members who wanted the Indiana State Medical Association to bring its pathology exhibit to the AMA session in Columbus. Dr. Frank B. Wynn of Indianapolis was in charge, but it was Dr. Platter who made the showing possible at the Columbus meeting.

Columbus was taxed to capacity by attendance at the meeting. Scientific sessions were held in the old Grand Opera House on State Street and in the House and Senate chambers in the State House.

"It is only fitting that the Council on Postgraduate Programs should honor Dr. Platter at the San Francisco meeting," said Chairman J. Arnold Bargen, M.D., of Temple, Texas, in announcing the award. "He contributed his knowledge and skills in the early days to unfold the drama of medicine, thereby helping to educate the prac-

ticing physician in his work. Dr. Platter's selfless toil and devotion in behalf of medicine through the years is a heartening chapter in the history of the profession."

Dr. Bargen said that Dr. Platter is being specifically honored "for his pioneering theories and spirit in promoting the first scientific exhibit of the American Medical Association in Columbus in 1899."

The exhibit was highly successful according to a resolution introduced at that time in the AMA House of Delegates by Dr. Charles E. Slocum, Defiance, Ohio. The resolution said that "this Association hereby commends the efforts of the Indiana State Medical Association in preserving pathologic specimens and exhibiting the same at this (Columbus) meeting. This exhibit is worthy of the attention of every member, being a good example of what careful and persistent attention to pathology may accomplish in a short time when well directed. Such efforts are recommended to all societies as conducive to more careful and methodic diagnosis of treatment."

The resolution was adopted.

As a result of this Columbus exhibit, the AMA Scientific Exhibit was formed and from that humble beginning, the AMA Scientific Exhibit has been held at every AMA annual convention since then. Scientific exhibits at AMA conventions today number more than 300.

Despite his age, Dr. Platter is hale and hardy, and still serves as Secretary of Ohio's State Medical Board, a post he has held since 1917. In physicians' offices throughout that state an estimated 80% of the licenses displayed bear the signature of Dr. Platter, who set up his first office when Grover Cleveland was president.

Advertising and particularly pharmaceutical advertising is an essential component of any medical journal. A major portion of the financial budget of *The Journal of the Indiana State Medical Association* is derived from advertising. Advertising in general is therefore essential in a financial sense. Advertisements for drugs and other therapeutic agents are also essential from an educational viewpoint.

Important drugs and especially newly-introduced drugs are described in advertisements in such a way as to make a state medical journal equivalent to a preview of the Pharmacopeia for next year. Readers are urged to consult the index of advertisers each month and tell detail men that you appreciate the advertisements of their companies; and if there are any whose company's advertisements do not appear, ask the detail men to arrange for such advertisements.

Guest Editorials

Too Many Chiefs

THE NUMBER OF SPECIALISTS has finally equaled that of family doctors, the general practitioners, and bids fair to become a rank majority in the near future. And then they'll become ranker and ranker. Whether the influence of Chesterton's sage remark that "the more a man looks at a thing, the less he can see it, and the more a man learns a thing the less he knows it," is a factor or not, the ranks of the specialists with their intramural differentiations are, nevertheless, expanding with galactic dizziness.

As the public must be served in all phases of medicine, at least two alternatives present themselves; the specialists will have to general practice (already some, driven by economic necessity, function as family doctors while maintaining the semblance of specialty practice), or other practitioners of the "healing arts" whom some of us regard with patronizing mien will fill the void left by the fading family doctor. By the way, notice the metamorphosis in the profession of nursing care in recent years.

Perhaps medical schools should teach the practical as well as the academic phases of medicine, and stress the complementary but

distinctive roles of the personal family physician and the specialists. Finally, at the hospital staff level the family physician should face a climate of co-operation and opportunity for advancement in privileges as befits his talent and verve. There is no ceiling in a democracy. Myrmidons belong in "the slave state." Better to heed Virgil's bit of philosophy, "one finger being all thumbs; the right hand loses its cunning." The public needs family doctors, and the public will be served.—Franklin F. Premuda, M.D., co-editor, *The Lake County Medical News,* Vol. XXVI, No. 2, Feb., 1964.

To Keep the Wheels Turning

THE RECENT SURGE of hectic activity in regard to legislation affecting the practice of medicine, and, *ipso facto* the health of the nation, has brought into prominence men who are the wheel-horses in organized medicine. They give much of their leisure time, often with some sacrifice of comfort and safety because of vicissitudes of travel to various meetings. This work goes on continuously, through the entire year, and the legislative angle is only one of a multitude of activities essential to the State Medical Association. Much of this work is taken for granted by members not actively engaged in association affairs, much the same as electricity and water supply are taken for granted.

On the other hand, some of the most valuable new ideas come from the so-called "grass-roots,"—from those who are not "medical politicians." The "old" wheel-horses then meet with the "younger" challengers at the conference table, frequently resulting in a new team to get something done. This process has been greatly facilitated by our present set-up of commissions, each with representatives from every district, and surely many a member not previously involved in organizational work has been favorably impressed as he has met with a commission in action.

New blood is continually needed in this work, and if *you* are asked to participate, don't turn it down without a trial. Your attention is called, in this regard, to an article quoted elsewhere in this issue* which mentions some of the rewards in this type of endeavor.—A. W. Cavins, M.D., Terre Haute. ◄

*Medical Panorama, p. 474.

Editorial Notes . . .

Senator Vance Hartke reports that there are over 100,000 Hoosiers over 65 who are not receiving Social Security benefits. The Senator accounts for some of this number by stating that some of them are not eligible, but seems surprised that everyone who is qualified is not on the gravy train. His press release on the subject infers that many of the eligible oldsters are farmers. Farmers are usually self-reliant individualists—could it be that there are that many self-reliant Hoosiers who do not care to be on a government dole?

More than 700 institutions in Indiana, providing care for the aged and chronically ill, now come under the rules and regulations of the Indiana Health Facilities Council. W. Dean Mason, Th. D. is the chairman. A 1963 law places a variety of such institutions under the Council with the State Board of Health designated as the administrative arm of the Council. Dr. Mason sees sanitary deficiencies and fire hazards as the major problems in boarding homes. A second category, county homes, may now be licensed as nursing homes and receive welfare funds. Philanthropic homes, under the new law, must be licensed. Many of them were licensed before on an optional basis and most of them are complying with existing rules.

Glenn W. Baker, of Cedar Rapids, Iowa, a junior in Indiana University School of Medicine, is one of 29 U. S. medical school students who have been awarded Foreign Fellowships this year by Smith Kline &

French Laboratories. The award allows each student to spend ten weeks at a foreign medical mission. Mr. Baker will go to Centre Medical, Bangui, Central African Republic.

Surgical treatment for pulmonary tuberculosis in VA hospitals has declined each year for the past five years. The decrease is thought to be due to the effectiveness of drug treatment. The total number of patients in VA hospitals declined last year, but the number of operations declined even more.

Gary physicians received a well merited citation in AMA *PR Doctor* recently. The doctors' division of the Gary United Fund campaign led all other divisions and almost doubled the highest amount they ever contributed. Lake County Executive Secretary, John Twyman, served as the general campaign chairman. The Lake County Society has received much praise and congratulations for public spirited work.

Workers hear only of the one-fourth of one percent increase in deduction from pay which is figured to cover Fedicare expenses. They don't hear much of the one-fourth of one percent the employer throws in, and they don't hear anything about the broadening of the base for the tax from $4,800 to $5,200 per year. C. Wilson Harder, president of the National Federation of Independent Business, finds that if this tax had been collected in 1963 the result would have been an increase of $3,460,200,000. This amount of course would not be any place close to the enormous expense of Fedicare, but at this level amounts to over 25% of the recently passed tax cut.

Indiana is one of eight states in which the American College of Radiology is sponsoring the formation of state chapters on a trial basis. Dr. Wallace Buchanan of South Bend is Chairman of the Board of Chancellors of the College and Dr. John Beeler of Indianapolis is a member of the Council Executive Committee.

The AMA-ERF loan fund has made a total of 11,875 loans for a principal amount of almost $14 million. Eight thousand four hundred and thirty students, interns and residents have been accommodated in the two-year period the fund has been active. Already 319 borrowers have repaid some of their loan and 58 loans are paid in full. It is estimated that it will be another seven or eight years before repayments are high enough to stabilize the fund and make additional contributions unnecessary. In the meantime the fund is being enlarged by physicians and industry in about equal shares.

The VA is beginning to issue to its patients the AMA emergency medical identification card to indicate conditions such as epilepsy, diabetes, allergy and special medication which might create special hazards if the patient was unconscious and unable to give information.

The Army is counteracting a high incidence of infectious hepatitis in Korea and South Vietnam by administering gamma globulin to all personnel who expect to remain in either theater for longer than 30 days. A second dose is given to individuals who remain for as long as five months. It has been customary for some time to administer a single dose to persons known to be exposed to infectious hepatitis. This produces a temporary passive immunity. The incidence of hepatitis in Korea and South Vietnam is high enough (10 times the Army-wide incidence) to warrant the two dose method, which produces a permanent immunity.

It has been generally believed that cigarette smokers of long standing do not decrease their chances of developing lung cancer if they stop smoking. However there is good evidence that patients with emphysema and bronchitis who cease smoking have a much better mortality rate than those who continue to smoke. Mitchell, Vincent and Filley reported in the *JAMA* that after 20 years of not smoking, their patients had demonstrated about a 50% mortality, whereas patients who continued to smoke had almost all died during the 20-year-period. Similar improvements in mortality have been reported for coronary occlusion.◄

President's Page

The Indiana State Medical Association was fortunate in having the Reverend Dr. Paul B. McCleave, Director of the AMA Department of Medicine and Religion, visit state headquarters last month. He was here to formally inaugurate Indiana's medicine and religion program.

The committee of our association responsible for the program invited the state leaders of all religious faiths to meet with the Rev. Dr. McCleave to hear him explain the program. There was excellent attendance.



This program, designed for the physician to invite the local clergy to sit down and discuss their mutual problems of total patient care, is outstanding in my opinion. It is one in which the doctor is asking for the clergy's help with the patient. An opportunity is also afforded for the clergy to become more familiar with medical terminology and technics.

A movie "The One Who Heals," depicting four separate situations commonly encountered is the spring board for discussion—it will be available to any county society upon request.

Future problems involving patients needing the heart-lung machine, the kidney dializer and those having had successful transplants were also discussed in the light of possible emotional complications needing the help of both the physician and the clergy.

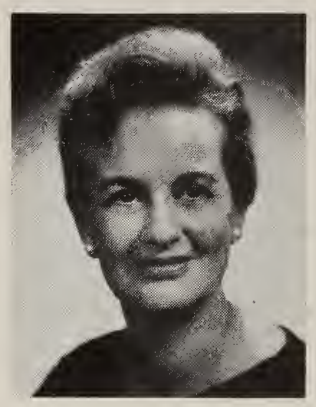
I am hopeful that each county society or hospital staff or groups will inaugurate the program. The clergy will be expecting your call, I am sure.

Donald E. Hood

The Woman's Auxiliary

REPORTS TO ISMA

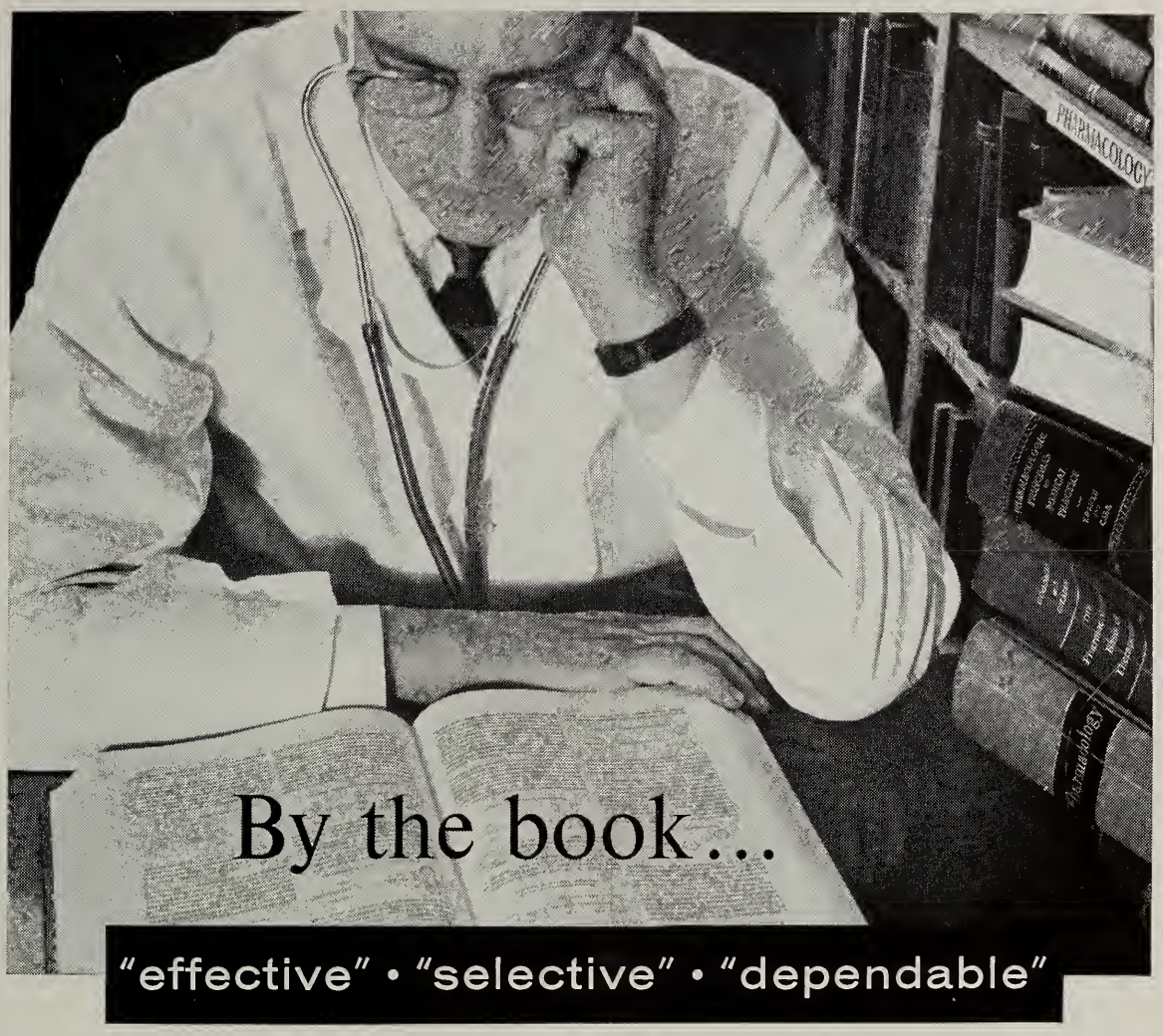
At state and national meetings during the past year, speakers have repeatedly advised auxiliary members to take an ACTIVE INTEREST in the AFFAIRS OF GOVERNMENT. We have been told to know which candidates believe as we do, to be sure of our facts, and to talk among our friends so as to help elect candidates who will preserve our AMERICAN HERITAGE.



At the AMPAC breakfast at the AMA interim meeting in Portland, Oregon, Dr. Durwood Hall, Member, House of Representatives, told delegates and auxiliary representatives, "The doctor who is not interested in politics is like the drowning man who has no interest in water." His closing statement was, "All we need to destroy civilization is for the right people to fail to KEEP OUR FREEDOM!"

Legislation is being emphasized within the auxiliary. We are to cooperate with the county medical societies and well might become a "politician's dream." Doctors, get busy and challenge your wives to become active in local politics!

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Research in the Service of Medicine

The first of three articles on medical staffs, hospital committees and medical records.

Robert's Rules of Unparliamentary Procedure

I. A Study in the Manipulation of a Hospital Staff

IAN ROSE ("Robert Rose"), M.B., B.S.
Kamloops, British Columbia

"Democratic government is the process whereby the decision of one man becomes the will of the people."

—Free translation from the Ojibway (attributed to Sitting Bull)

A RELATIVELY large body, such as the medical staff of a hospital, can be controlled democratically provided its psychology is understood. Its actions are dependent on certain specific laws, and once these are defined its reactions can be predicted in a given set of circumstances. It follows from this that matters can be presented to it in such a way that it will act in a manner predetermined by the presentor. This response is independent of both the individual profit of the members and the corporate good of the body.

The medical staff of a hospital is under the illusion that it governs itself. It is, in fact, governed by the committees; these are the active elements that do the work. It is perfectly clear that a committee decides what the medical staff should do in a particular matter and presents its conclusions to the staff in such a way as to cause them to adopt or reject the proposition, in accordance with the desire of the particular committee. A proper understanding of the ways in which a committee can function and of those circumstances which make it difficult or impossible for a committee to act is a primary essential in the study of the manipulation of a medical staff.

An active committee should consist of five members. One of the members, not the chairman, should be the active ingredient —i.e., someone close to and under the direct influence of those running the staff. He should not be the chairman. On the other hand, the chairman of the committee preferably should be someone with no personal involvement in the matter of the committee. Examples of suitable chairmen are the Radiologist for the Tissue Committee, the Pathologist for the Pharmacy Committee, and so on.

The other three members may be recruited at random because they do not matter. In practice it will be found that the committee never meets with more than its basic quorum of three—two men must always be unable to attend. Overkeenness on the part of members can be countered by manipulation by the active member; he arranges for the meeting to occur at times when he knows two of them will be occupied or on vacation.

If it is desirable for any reason that a committee should not act efficiently, it should be constituted as a large one. This may, in fact, be stated as the *Law of Committee Effectiveness*, thus:

"The effectiveness of any committee is in inverse proportion to the number of its members over five."

Thus if it is decided that it is wise for a problem to be lost and forgotten, it should be referred to a special committee and this be constituted to consist of as many people as possible.

The law of committee effectiveness hardly needs explanation. It is obvious that the larger the number of members in the committee the more difficult it is to obtain a quorum, and the greater the controversy

that will occur when it does meet. The result is the least possible action on its part.

It is sometimes suggested that committees should consist of less than five members. This is inadvisable for the following reasons:

A committee of two creates the impression of collusion; this is to be avoided at all costs.

A committee of three may be difficult to manage because the one random member may turn out to be a difficult person with a mind of his own who cannot be left out of meetings without creating the impression of collusion.

A committee of four is possible but should be avoided on the pretext of the even vote. Five is the ideal number because it allows the active member to select that one of the three random members who is most suitable for his purpose, i.e., the one he can lead into supporting the report he wishes to return to the medical staff.

Natural developments in the history of any medical staff which is growing in numbers are a progressive narrowing of the scope of medical practice and an increase in the amount of paper work; the latter is in direct proportion to the rate of growth in numbers of the medical staff. This may be expressed as the *Law of Increasing Complexity*:

$$X = \frac{A \sqrt{(n/p)}}{10},$$

where A is the number of new members of the medical staff over a 10-year period; n is the number of certified specialists; p is the number of general practitioners. The product x is the time interval between the appearance of one new documentary form and the next.

Restrictive Rules and Regulations

Axioms:

1. *It is simple to pass a restrictive rule.*
2. *It is almost impossible to delete a restrictive clause from the rules and regulations.*

In view of the axioms relating to restrictive rules, it is essential that all undesirable proposals of restrictive nature be dealt with in the only way possible, i.e., by losing them in the machinery of the medical staff. Because of the importance of this section the matter will be dealt with at some length. *Note*: To defeat restrictive proposals in open motion is pointless as they will recur either in the same or in a disguised form almost immediately.

A proposed restrictive rule should be allowed to be duly moved and seconded and the discussion allowed to proceed for 4.5 minutes.

It should then be moved that the matter be referred to a special committee appointed by the meeting. This secondary motion will usually succeed if the reason is given that there are many technical aspects to the main motion that could be better dealt with in committee, rather than wasting the limited time of the general meeting.

It is then essential to make the special committee as large as possible (see the Law of Committee Effectiveness). The person moving the motion to refer to committee will generally be offered the chairmanship, which he should refuse, but he should agree to serve as a member. It is then wise to allow two or more people to be appointed before proposing additional members. These additional members should then be proposed after asserting the extreme importance of the matter and suggesting that a wide variety of opinion should be represented on the committee.

In accordance with the Law of Committee Effectiveness, the greater the number of members, the greater will be the tendency for the undesirable rule to be lost. If the committee does bring in a report in six to 12 months (this will only rarely occur), all the emotions aroused by the original proposal will be dead by that time. In this eventuality, other losing procedures are applicable such as asking that the committee clarify a certain point before the report is accepted. It is often possible at such a time to suggest one or two extra members for the committee on the pretext that they will be valuable in the elucidation of the obscure point.

If, however, the motion to refer into committee is defeated, the discussion should be allowed to continue for another 4.5 minutes. Then the motion to postpone indefinitely can be tried. This may succeed if the chairman either does not understand the motion or is also in favour of forgetting the whole

thing. The essence of success with this motion is correct timing and a stop watch is desirable; this ploy carries the main motion into sudden oblivion.

However, the suggestion to alter the motion of indefinite postponement to postponement to a certain time should be accepted with good grace, because in a month or two enthusiasm for the undesirable resolution will have abated. Furthermore, during the time gained by postponement it may be possible to incapacitate the man who moved the offensive clause and prevent him attending the subsequent meeting. This, of course, requires finesse, such as tripping him on the way to the meeting and thereby putting him in bed with a fractured femur.* Crude and obvious measures, such as open physical violence or poisoning his tomato juice, may well prejudice uncommitted members of the medical staff against one, and are to be avoided.

If the motions to postpone as well as those to refer to a committee fail, the existence of a strong pressure group behind the main resolution should be suspected. Further, the possibility should be considered that a key member, who would be expected to exercise considerable influence opposing the resolution, has been kidnapped or otherwise prevented from attending. The situation is now serious and all appropriate cards (described immediately below) should be played in rapid succession.

An amendment subtly drawing the teeth of the main motion can be moved, but it is unlikely to succeed at this stage if other gambits have failed.

The motion that the controversial resolution be "laid on the table" is the last move; it allows time for the circulation of notes to all those members opposed to the resolution, directing them to leave the meeting on various pretexts.

When somebody calls for the main question, it should be pointed out that there is no longer a quorum present. The meeting has, therefore, ended. Subsequently it is then possible to organize effective opposition to the resolution for the next meeting.

The converse of this situation is, of course, equally valid. When it is found desirable to pass some restrictive clause, it is quite essential to have the whole process completed at a single meeting. It seems that any restrictive rule creates a good deal of short-lived excitement and highly emotional enthusiasm. For this reason restrictive clauses bearing on the medical staff should always be included in the rules and regulations, which do not require notice of motion, and not in the bylaws, which generally have to be announced beforehand. It is, of course, common sense to sandwich any slightly controversial rule between such routine matters as the reports of the medical records committee and that of the tissue committee. In this way many restrictions imposed on the medical staff go through not only unopposed, but unnoticed.

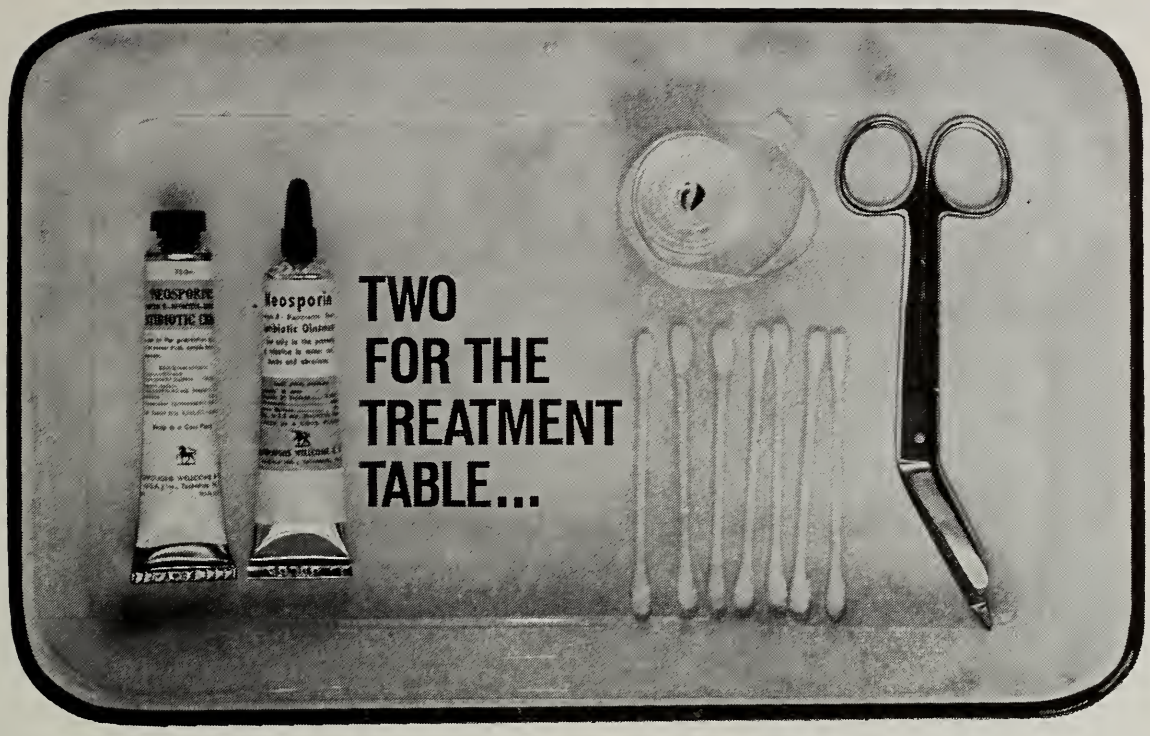
The removal of a restrictive clause from the rules and regulations of the medical staff is, as has previously been stated, almost impossible. However, it has on rare occasions been done, and an analysis of the processes by which it can be achieved will be dealt with in a separate paper.

The Concentration-time Barrier

It will be noticed that the figure of 4.5 minutes has been identified on a number of occasions as the optimum time for discussion before bringing in a side-tracking motion. This has been established experimentally. An analysis of the psychology behind this figure may be of interest. It has been shown that two minutes is the longest time that the average doctor is able to concentrate on a given subject. Thus, during the first two minutes of the discussion the physician or surgeon will follow the proceedings carefully. At the end of 120 seconds his mind will wander and he may start a small side-discussion with one or other of his neighbours. In another two minutes he will have used up his concentrating powers on the second discussion and his mind will return to the business of the meeting. The discussion going on will no longer be new but will strike a familiar cord in him and, in approximately 30 seconds, he will begin to feel bored and restless.

If, at this time, a proposal is made which takes the responsibility for considering the matter in hand away from the individual

* It is to be noted that this is harder with the young than with the elderly.



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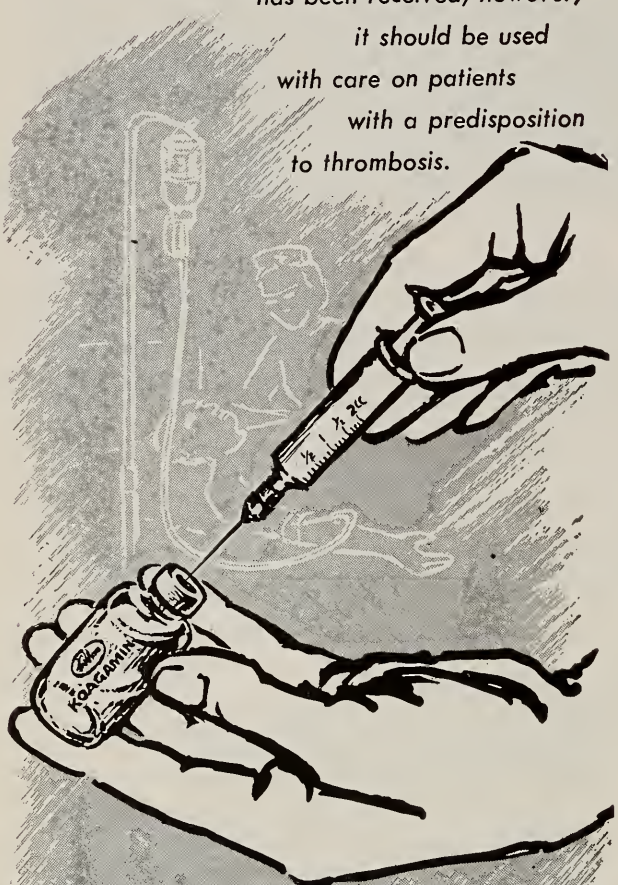
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PROCEDURE

Continued

physician, he will generally embrace it. Especially so because he knows that, before any final decision can be reached on the matter, the question has to be brought before him again, and his pride and vanity remain intact. In fact, he can tell himself that the detailed discussion of the minutiae of the problem in hand are a waste of his time, which is very valuable and should be devoted to important and broad decisions.

If, however, the discussion is allowed to proceed for more than 4.5 minutes his boredom will express itself in a demand for the question in order to get the whole thing over with. A side-tracking issue made at this time may well lead him to feel that after he has devoted "all this time" (something between five and eight minutes) to the matter, no further discussion is needed and the suggestion to refer into committee is an insult.

A knowledge of these basic laws is essential in the effective manipulation of a medical staff. Other laws, in particular those related to specific committees of a medical staff, and how to utilize them in practice will be the subject of subsequent papers.—Reprinted from *The Canad. Med. Assn. J.* 88:1019-1021, May 18, 1963. ◄

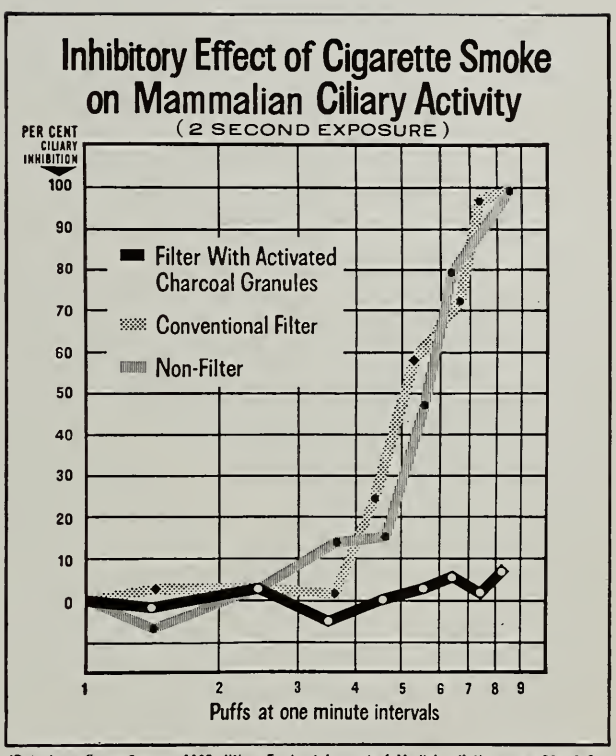


"For heaven's sake, Milford, you never ask to x-ray a man's billfold first!"

respiratory cilia in *in vitro* experiments. (see chart.)

Dr. Kensler points out in his paper referred to above: "Although it is recognized that these *in vitro* findings may not be directly extrapolated to the effects of cigarette smoke on human pulmonary tissue the use of the charcoal-granule filter will obviously reduce the level of exposure of the non-ciliated as well as ciliated bronchial and alveolar cells to potentially harmful smoke components."

The specially treated charcoal-granule filter discussed in the Kensler and Battista paper was the prototype of the one which is now available to the public on Lark cigarettes. Since some of your patients may have heard of this filter through the lay press, and may inquire about its basis in science, we believe you may wish to have the information at hand.



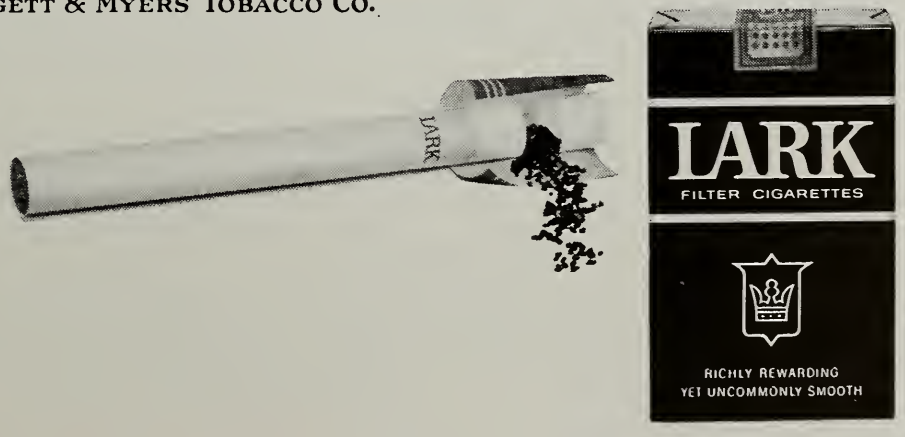
(Data from figure 6, page 1165, "New England Journal of Medicine," November 28, 1963)

Chart shows inhibition of the mammalian ciliary activity by the irritating gases in cigarette smoke:

1. The screened lines represent conventional filter and non-filter cigarettes and show how they produced 50% ciliary inhibition after 5 to 6 puffs and 100% inhibition after 7 to 8 puffs.

2. On the other hand, the filter with activated charcoal granules, represented by the solid black line, produced no significant inhibition (less than 10%) when the whole cigarette (8 puffs) was smoked.

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DAY BY DAY WITH THE F D A

From the FDA Reports on Enforcement and Compliance.

Staphylococcal toxin in food may now be detected and identified by a new method which eliminates the necessity of culturing the organism. FDA scientists have perfected the method after 15 years of work. It involves the use of specific antitoxin and the test may be completed in three or four days in contrast to older methods requiring twice as long. Staphylococci are responsible for most of the food poisoning cases.

* * *

In two separate actions a Hoosier seed company was fined for shipping shelled corn which contained a non-permitted pesticide and a drug salesman was found guilty and fined for selling prescription drugs without prescriptions. Similar actions involving illegal handling of potent drugs have been taken in several other states.

* * *

The National Fisheries Institute has adopted and will recommend as standard the custom of distributing smoked fish as frozen food. The action was taken on the recommendation of FDA and is designed to avoid the hazard of botulism. In addition the institute is instigating a review of all sanitation and handling practices.

* * *

FDA analyses of "Krebiozen" ampules have shown that those sold before 1960 are different from those sold in 1963, and that neither contains any of the powder identified as "Krebiozen." Tests have also shown that "Krebiozen," now identified as creatine monohydrate, will not dissolve in mineral oil. Before 1960, the ampules contained nothing but mineral oil. Since then the FDA has found mineral oil plus minute amounts of amyl alcohol and a derivative of creatine which is soluble in mineral oil.

Tolerance of chlordane on foods will be eliminated according to a proposal by FDA. Since 1955 up to 0.3 parts per million of chlordane have been allowable. New determinations of safety of pesticide residues have indicated the necessity to change the ruling.

* * *

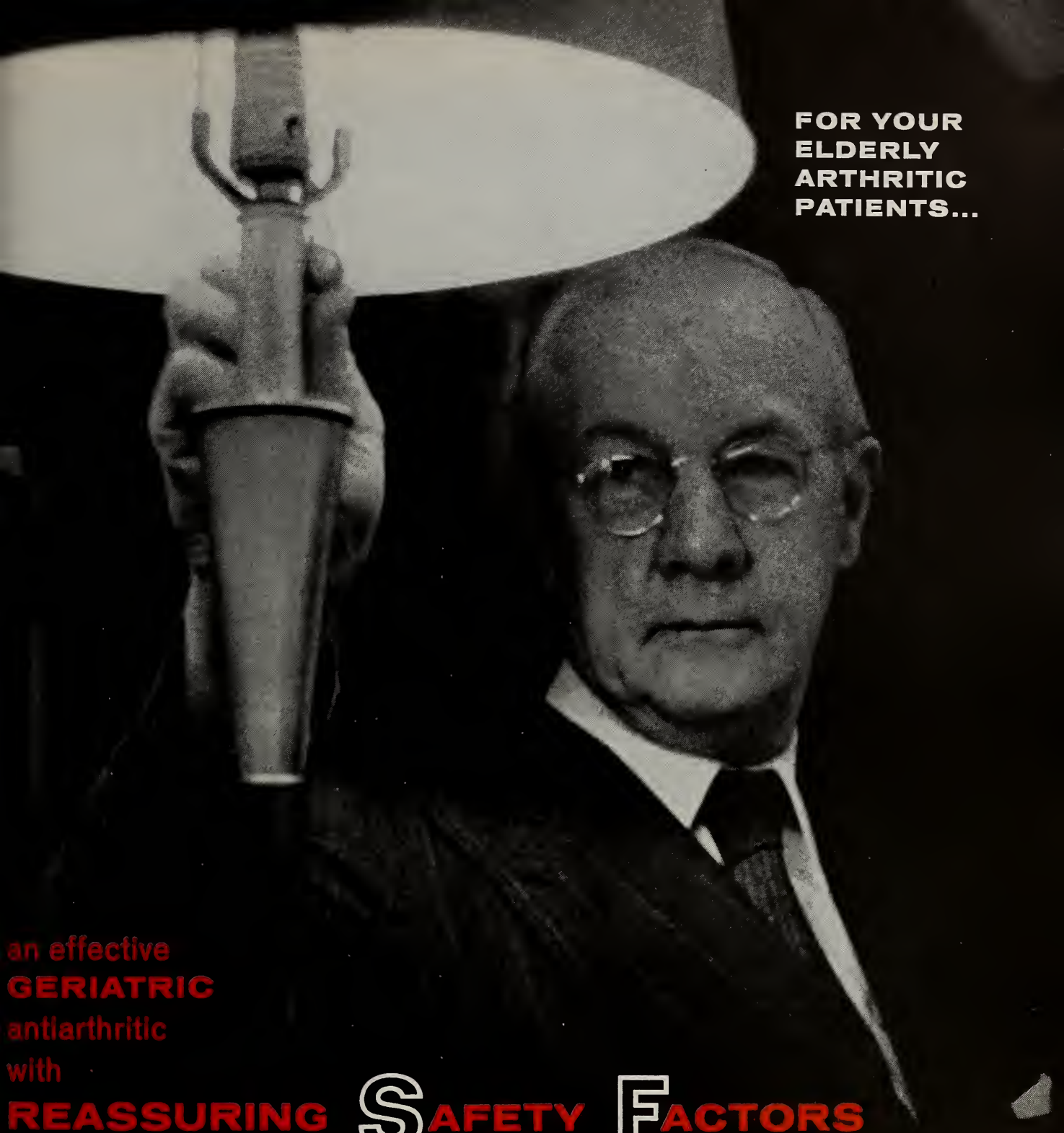
"Million Dollar Egg Mystery"—43 cases of a new product Kraft's "Miracle Egg" have been seized at Fort Wayne. The labeling in part was "Instant Egg White Mix With Golden Egg Yolk Substitute, Low In Cholesterol, Low in Saturates." Ingredients were identified as dried egg whites, nonfat dry milk, rice flour, safflower oil, phosphates, dextrose, salt, artificial flavor, color and riboflavin. Mystery—FDA contended that the product was misbranded because the label and promotional material suggested that it was effective in controlling the cholesterol level of the blood, that it could be used generally as a substitute for eggs in cooking and that it was not labeled as an imitation of dried eggs.

* * *

Three thousand three hundred plastic disposable-type syringes manufactured in Indianapolis were seized on charges of adulteration and misbranding in that the product was non-sterile. The syringes were reclaimed and resterilized by the manufacturer.

* * *

Terre Haute was the site of a seizure by FDA of a lot of wallpaper grease spot remover manufactured in Springfield, Ohio. The remover contained a petroleum distillate and did not carry warning labels required of hazardous household chemicals.◄



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Future Needs for Medical Education Programs to be Topic of State Survey

INDIANA UNIVERSITY has announced the engagement of Booz, Allen and Hamilton, Inc., Chicago, nationally recognized management and educational consultants, to conduct an intensive study to determine future needs for medical education programs in the Hoosier State.

President Elvis J. Stahr said the consultants have developed a study plan over the past few months and will complete the survey itself well in advance of the next session of the General Assembly. The I.U. Board of Trustees has approved expenditure of up to $30,000 for the survey.

H. Lawrence Wilsey, vice-president of the consulting firm in charge of its institutional management divisions, and Dr. Lowell T. Coggeshall, University of Chicago vice-president in charge of medical affairs and former president of the Association of American Medical Colleges, will direct the survey team.

Wilsey said that the survey team will consult representatives of the Indiana State Medical Association, the Association of American Medical Colleges, the Council on Medical Education of the American Medical Association, community leaders in a number of Indiana cities, and executive and legislative leaders of the state.

The study team will also consult with officials of I.U. and its School of Medicine, Purdue University, Ball State Teachers and Indiana State Colleges and a number of the private institutions of higher education in the state. The survey, which is expected to reach into every corner of the state, will become a blueprint for the development of Hoosier medical education in the foreseeable future.

Two paramount questions will guide the survey. These are:

1. How best can an increasing number of young Hoosier men and women who wish to enter the field of medicine be provided with the full range of professional education and training they will require?

2. How can medical education programs within the state most efficiently help ensure that adequate numbers of physicians will be available to provide the medical care needed by a growing population?

Plans Await Survey Results

Plans to launch such a survey were announced last November 15 when Willis Hickam of Spencer, president of the I.U. Board of Trustees, said that the board would take no new major action in enlarging facilities for medical education until the reports of a thorough and objective study are available.

Current plans already include, however, the construction of new clinical facilities in a new 714-bed teaching hospital in Indianapolis, which is needed for the enrollments now committed. Part of the funds for this have already been appropriated by the General Assembly.

Since 1908, the only medical school in the state has been the Indiana University School of Medicine, and in recent years it has grown to be one of the nation's largest. This year it admitted 201 freshmen medical students at the medical center in Indianapolis and 15 in its special combined-degree program on the Bloomington campus. This latter program was established in 1959 and is under the direction of the School of Medicine in cooperation with the Division of Biological Sciences.

The I.U. Medical School is currently responsible for the education of 702 undergraduate students working toward M.D. degrees; 203 holders of the M.D. degree who are taking advanced training as interns and residents; 73 students working toward advanced degrees in the basic medical sciences; 139 students in training in a variety of allied health sciences; and postgraduate training programs available to practicing physicians throughout the state.

The I.U. School of Medicine was established in 1908 as a consolidation of all the

then existing medical schools in the state. From the early 1830's until 1908, a large number of medical schools, most of them small in size, were established and existed for various periods of time.

Survey Considerations

Important questions to be considered in the survey include:

How many qualified students can be expected to apply for enrollment in medical schools in selected future years, for example, 1965, 1970, 1975, 1980?

What opportunities will exist for Indiana students to study medicine in other states?

What will be the needs of the state for physicians as the population grows and changes in location? To what extent should state-supported medical education be expected to help meet that need?

What scope, levels and quality of medical education will be required if Indiana in years ahead is to meet anticipated needs?

What will need to be the relationships among programs of instruction offered medical students, graduate medical education, instruction in the basic sciences, paramedical personnel training, medical research and patient care?

What numbers and kinds of faculty members will be needed, and will there be faculty of desired quality available?

Will the present medical school programs be able to expand to meet future needs without significantly impairing the quality of programs offered?

Will a second medical school be needed? If so, when?

If additional medical school facilities are needed, where should they be located, taking into account educational and construction costs, administrative considerations, relationships to graduate and research programs and other relationships?

What institution should be responsible for the operation of needed additional facilities—Indiana, Purdue, Ball State, Indiana State or a private college or university?

What will be the costs of meeting the foreseeable future needs of the state for medical education? How can these costs best be financed? ◄

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Looking Ahead at the AMA*

F. J. L. BLASINGAME, M. D.†
Chicago, Ill.

SOCRATES SAID: "The unexamined life is not worth living." To put it another way, it is laudable to practice examination of our lives. This attitude applies not only to us as individuals but also to an organization such as the American Medical Association. Thus, a review and examination of its activities at this Third AMA Institute is fitting.

I. Participation

In assessing an organization like the AMA, one reasonable yardstick to consider is member participation. I am pleased to report that we recently reached an all-time high of more than 200,000 members.

This recent growth is an indication of vitality. This steady rise in membership has been realized despite attacks by our adversaries. Perhaps an attendant blessing to these attacks has been an even closer cementing of our membership.

Though participation has improved, every effort needs to be expended to see that more physicians become members of the AMA, learn more of its works, and become an active, informed part of its life. As one step in this direction, studies are underway in several states to examine the reasons why some physicians fail to join the AMA. These studies may be extended nationwide in the hope of learning the reasons for non-participation in the hope that we may increase membership even more.

Participation leads to understanding and makes for motivation and action, which should not only improve the AMA but also enrich the life of the physician.

As stated in its constitution, the purpose of AMA is: ". . . to promote the science and art of medicine and the betterment of public health." Greater physician participation means fuller realization of this objective. Of necessity the AMA staff has increased. In the past year, 125 new employees were added, bringing our total to 850. The staff is composed of persons possessing a wide variety of talents, and its members are busily and devotedly engaged in assisting the association carry out its programs.

Architects are finalizing plans for the expansion of the headquarters building. The new construction will extend to State Street, and this extension will increase the floor space of our building by approximately one-third.

New programs, expansion of staff, and facilities require more funds. I am pleased to report that the past few years have seen a continual growth in the AMA income. In the last five years it has increased approximately 100%. In 1963, the anticipated income is $21,653,000, and anticipated expenditures, $20,957,000.

It is true that the 1963 figures reflect the increase in AMA membership dues. However, it is equally true that we experienced a continued rise in other revenue sources. We hope and believe that we can maintain this steady growth picture. In fact, it is imperative that we do so. It is clear that we cannot meet the problems of tomorrow on income of yesterday or today. In addition, the American Medical Association Education and Research Foundation had a budget in 1962 of $2,300,000, and will likely increase this amount for 1963.

II. Changes In Organization

The annual meeting in Atlantic City demonstrated that the AMA will make significant organizational changes if they are needed. The Board of Trustees was enlarged from 11 to 15 members. The terms of office were also changed from five years to three years.

The Board of Trustees and the House of Delegates also appointed a committee to study workings of the sections of the house and to attempt to redefine the role of the

* Delivered before the AMA Institute, Chicago, Ill., Aug. 22, 1963.

† Executive Vice-President, American Medical Association.



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sections. Some of the decisions reached by the committee may prove difficult to implement. One major difficulty comes from the sections failing to correspond in name and/or number to the specialty groups existing in present day medicine. Additional study of the problems involved appears necessary.

Another important committee, with Dr. Gunnar Gundersen as chairman has been appointed to study the organization of the House of Delegates—its size, composition, committee structure, and reference committees. This study will require at least a year to complete and can have far-reaching effects.

The recent reorganization of the Division of Environmental Medicine and Medical Services at AMA headquarters is a demonstration of the continuous effort being made to improve our administrative set-up. Specifically, this reorganization involved the creation of four new departments—the Department of Community Health and Health Education, Department of Governmental Medical Services, Department of Hospitals and Medical Facilities and the Department of Medical Finance. The new organizational structure is a departure from the previous pattern of relating departmental functions specifically to a council or committee.

Under the new structure, related staff functions will be grouped together in departments to provide greater flexibility in the utilization of staff resources by the House of Delegates and by all councils and committees within the AMA. In no sense does such an arrangement alter the functions of the various councils or committees being staffed by the Division of Environmental Medicine and Medical Services nor their relationship to the House of Delegates or the Board of Trustees. These above changes apply to staff.

III. Scientific and Health Education Activities

The scientific and health education activities have been, and continue to be, the cornerstone of AMA.

At the Atlantic City meeting, announcement was made of plans for the establishment of the AMA-ERF Institute for Biomedical Research. The institute will concern itself with an intensive and fundamental study of life processes, particularly as related to intracellular mechanisms.

Another of a group of substantial programs of AMA-ERF is the Student Loan Program designed to lessen the financial barrier in medical education and assist in increasing the supply of physicians. Thus far, more than 8,500 loans, totaling more than nine million dollars in principal, have been made since the project began in February, 1962. This record is phenomenal. This program merits your sustained interest and support.

Here are a few additional highlights:

1. AMA is jointly sponsoring with the American Nursing Home Association the new *National Council for the Accreditation of Nursing Homes.* This council will carry out a nationwide program to promote high standards among nursing homes. It should contribute significantly to the improved care of our elderly citizens and to the expansion of qualified nursing homes.

2. A new AMA *universal symbol for*

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emergency medical identification has been developed. This new alerting symbol will tell first aid workers at a glance that its wearer has a condition requiring special attention.

3. Another program of note is our new and expanded *Central Registry of Adverse Reactions to Drugs and Chemicals.* The AMA's "early warning system" for the guidance of physicians in prescribing drugs for patients will be an important part of our continuing program to service the public.

4. AMA carried out *an intensive campaign for vaccination against smallpox.* This campaign again identified the AMA as a leader in health education. We anticipate a similar program shortly on tetanus immunization.

5. *The First National Congress for Mental Illness and Health* was held in Chicago in October, 1962 under AMA sponsorship. This meeting resulted in a new drive for community-oriented mental health programs. A similar meeting is planned for early 1964.

6. A significant new AMA program which made major progress this year is the *Department of Medicine and Religion.* Established in September, 1961, the department seeks to create the proper climate for communication between the physician and the clergyman that will lead to the most effective care and treatment of the patient in which both are interested. At the Atlantic City meeting, the department premiered its new film, "The One Who Heals," and presented an outstanding program on medicine and religion. More than 4,000 persons attended the program which featured speeches by the Very Reverend Fulton J. Sheen, Dr. Edward H. Rynearson of the Mayo Clinic, and Reverend Dr. Paul B. McCleave, director of AMA's Department of Medicine and Religion. The film, "The One Who Heals" is excellent, and our communications people believe it will win a number of awards.

7. Looking to the future, we shall have *the Second National Congress on Medical Quackery* in Washington, D. C., on October 25-26.

8. *A National Conference on Environmental Health* will be held in Chicago on May 1-2, 1964. The purpose of this meeting will be to focus attention on health problems related to air pollution, water supply and pollution control, use of pesticides and ionizing radiation.

9. We are also looking into the possibility of sponsoring world-wide congresses on such major topics as nutrition, cancer, nuclear medicine, etc. We feel that such meetings will be another step by AMA in fulfilling its "umbrella function"—bringing under one roof the various scientific disciplines for a direct assault on a health problem.

IV. Communications

Communications activities have shown significant progress — as steps to increase our flow of information to the profession and the public.

Analysis of all AMA publications is being made to determine whether additional improvements can be made.

During the past year, the Communications Division distributed more than 12 million pieces of literature covering the entire spectrum of association activities. As

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you are aware, a program of distributing literature racks for physicians' offices has been started. This project is growing rapidly and will result in better health education and better public understanding of the AMA's work.

The Science News Department last year inaugurated a new project involving the production of a series of public health information features for weekly newspapers in easy-to-use mat form. More than 400 news releases on health topics were issued last year, and thousands of papers carried these items. A survey showed that one special feature on aging received a circulation of at least 45 million in daily newspapers. Health and safety spot announcements for radio, prepared by the AMA, are heard by millions. Radio stations carrying these items increased last year from 2,000 to 2,400, which added up to over 25,000 hours of public service time.

During the past year, the Magazine Relations Department made an intensive effort to show writers and editors that through closer cooperation with the AMA, they could render a greater service to their readers. As a result of this approach, more medical articles — containing greater depth and more accurate information — are appearing. We furnished material for 246 articles last year. We also received 126 manuscripts for checking and editing — exactly twice as many as a year ago.

In addition to assisting the Department of Medicine and Religion on its film, "The One Who Heals," AMA's Department of Radio-Television-Motion Pictures assisted in the production of three films on health care of the aged.

In preparation is a 30-minute film for lay consumption which will explain the past and present contributions to the public by the American Medical Association. Another film is planned for next year, which will show physicians the many services available to them at AMA.

As for television, I believe the medical profession has benefited tremendously from such series as "Ben Casey," "Dr. Kildare," and "The Eleventh Hour." As you are all aware, the AMA Physician's Advisory Committee on Radio, Television and Motion Pictures provides technical advice to these series and to many other scripts dealing with medicine.

At present, we are giving serious thought to the possibility of assisting in the production of a regular television series on significant *scientific* medical developments. Last week, conferences were held with the three major TV networks, and two of them expressed interest in this project. We must iron out some differences concerning the production of such programs, but we hope that we shall reach a satisfactory agreement with one of the networks.

The past year has brought a tremendous improvement in our liaison with other national organizations. Dr. Annis, Dr. Welch, and other AMA officers have done an outstanding job of getting our message across to the various civic, fraternal and professional groups. The AMA Speakers' Bureau has also had a busy year. Its 50 physician and laymen speakers made a special effort to address college groups since health care of the aged was the collegiate debate topic last year. This year high school students are debating this topic, and we shall again attempt to get our story across to them.

Very shortly, we expect the completion of a new, pocket-size paperback, informative book on the AMA by Pete Martin. Mr. Martin is one of the outstanding free-lance writers in the country, and we are confident that his book will give the public a real insight and appreciation of our work.

Also planned for the near future is an AMA sponsored contest on medical science reporting for five communications media.

V. Socio-economic Activities

The socio-economic area, including our legislative activities, has been the subject of considerable action. Our new program, "Operation Hometown" has given us a framework within which our grass roots campaign against the King-Anderson bill has been waged effectively. An analysis of the public opinion polls conducted by various congressmen indicates that our position is improving, but sustained work is required.

An important point in medicine's favor today is the progress which has been made

in the implementation of the Kerr-Mills law. This has been an area in which the AMA, the state societies, and their friends have made an outstanding record of progress. Despite formidable opposition by the Administration, 37 states and four jurisdictions have put Kerr-Mills MAA programs in operation or enacted authorization legislation. And all 50 states and the four jurisdictions now have OAA vendor payment medical programs.

As for the Mental Health and Mental Retardation bill presently before Congress, the AMA scored a victory recently when the provision on federal funds for staffing was knocked out by the House Interstate and Foreign Commerce Committee. It is interesting to note that this Administration bill embraces the concept of community-oriented mental health programs which was developed at the AMA National Congress on Mental Health.

The report of the three-year study by the Commission on the Cost of Medical Care will be given in full at the clinical session in Portland this December. The commission study is a very important one and will provide the public and the profession with a better understanding of medical care costs.

The AMA Disability Program was started last year and had an unusual member response, with some 45,000 physicians enrolling thus far in the program.

Now, pursuant to the request of the House of Delegates, the headquarters staff is tooling up to offer a program to members so that they may take advantage of the tax-deferred retirement program under the Keogh-Smathers law.

Financing Medical Care:

Last year at this AMA Institute, I commented on the need for a review of our approach to the financing of health care. I suggested a reconsideration of the traditional emphasis on first-dollar coverage and service benefits. I suggested an unbiased study of post-payment programs and installment approaches to low cost medical and hospital care, and major medical or deductible approaches to unexpected, catastrophic health care costs. I wish to emphasize this subject again at this meeting.

I recognize that in approaching this subject one must tread carefully because of the sensitive and complex inter-relationships of Blue Shield and Blue Cross, and of the Blue Shield-Cross plans with health insurance companies. The need for honest and candid consideration of these various approaches is more urgent, however, than ever before because of the pressure for King-Anderson type legislation, the increasing premium cost of health insurance and prepayment, the development of quality nursing home facilities and their coming coverage by prepayment and health insurance, the contentious resistance to fee schedules and their inequities, and many other developments.

I feel strongly that the entire *voluntary* health insurance and prepayment movement must be preserved, but I feel equally strongly that their preservation as free non-governmentally controlled enterprises is not likely unless certain basic changes are made in the kind of policies that are sold to the public. Specifically, it seems to me that the prepayment approach that emphasizes first-dollar coverage, and administered pricing of the vendors' services through fee schedules, must be revised if it is to remain an unsubsidized product that can be sold in a free, open market. Either the subscriber must bear a higher share of those health care costs which are expectable and recurrent, or the prepayment plans will look increasingly to the federal government to do so. The deductible must be incorporated into health care policies whether sponsored by Blue Cross-Blue Shield or health insurance companies, if policies are to be sold at a reasonable premium price and are to contain coverage protection against those health care costs which are most burdensome to the subscriber. I submit that the jolt to traditional community rating service benefits that this approach means to the Blue plans is more than offset by the ability to underwrite deductible policies by those plans due to their unique relationship with the providers of the care.

Image:

Finally, let us not suffer from image neurosis. We hear much talk about the image of

the American Medical Association. Many express misgivings about our image — others, while denying that it is unfavorable, press for projects that improve it.

The fact is that it is extremely difficult to determine — at any given time — what the AMA image is because it varies from one community to another; from time to time; from person to person; among levels of income; by education; by race, creed and color; by political affiliation; and in many other ways. When the AMA is cast as the symbol of opposition to the President of the United States, it becomes a good or bad image depending on the public reaction of the moment to the President. Every action that we take as an association affects some group favorably or adversely and thereby affects its reaction to us.

Any organization which dedicates itself to public leadership can expect to incite powerful reaction from those whose aims are threatened. This is especially true in controversies affecting the very nature of our society. We must not hesitate, however, to provide leadership, even though that leadership excites abusive counterattack from those whose objectives are thwarted.

In short, it is reasonable and proper to strive to project the best possible image to all our publics, but it must also be recognized that the image we project varies among these publics by place, by time, by income, by education, by subject and because of other events over which we have no control. Finally, the demands of leadership are far greater than the demands of successful image making.

A cartoon appeared recently in *The Chicago Tribune* showing Mr. Harriman and Mr. Rush gaily dancing around in a circle shouting: "He smiled at us! Khrushchev smiled at us!" The caption for this cartoon is: "You fellows sure he wasn't laughing?" This cartoon exhibits a subtle truth and points to the real dangers in seeking agreement just for the sake of agreement.

As Socrates put it, "The unexamined life is not worth living." In examining our lives and that of the AMA, we must examine our ideals, objectives, our philosophy and be capable of defending them effectively.

Today, we are being shown startling examples of faith by the Buddhist priests of Viet Nam. To uphold their religion and to protest the alleged discrimination of the government in power, a few of these priests have sat in the streets, poured gasoline over their clothing, and turned themselves into human torches.

While we are not called upon to testify so dramatically for our convictions, day by day, moment by moment we *are* tested. May this *re-examination* renew our courage and energies so that we shall measure up to the tests made *of us*. I have faith that we will. ◄



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Disgruntlementosis

A. W. CAVINS, M.D.
Terre Haute

A welcome defense of those who are often harshly criticized for the operation of their medical societies by those who are chiefly "sidewalk superintendents" comes from *The Journal of the Florida Medical Association* (February, 1964).

With organized medicine under fire on more than one front, constructive criticism is what we need. The following little piece is entitled "A Disgruntled Member," but as he progresses he offers a solution for relieving such disgruntlement:

* * * *

Show me a physician who takes no part in organized medicine and I will show you a disgruntled member of the Florida Medical Association. He vents his envy, compensates for his inadequacies, or salves his conscience by making sarcastic remarks about the medical politicians.

Every new generation has a tendency to disparage the old adages and conceptions. The old one that work is the source of the most happiness comes in for fun-poking particularly in the last few years with our 36 to 40 hour work weeks, et cetera, but doctors know how an idle brain really is the "devil's workshop." When a doctor becomes so highly limited that medicine only interests him in his own practice and not in the county, state, nation and world, he is losing too much of his work potential. A wonderful way for us to combat minor frustrations is to throw ourselves into a job which we know would benefit all of our profession.

There are so many aspects of work in the county and state societies that the particular interest of any doctor could be reached if he would just make a start.

Organizational apathy gets none of us anywhere. A sense of duty should make us work in our medical societies, but we know that is not enough motivation. The plain enjoyment of it should be enough to make everybody try it. It is a wonderful opportunity to swap ideas with our colleagues and to meet some really superior people.

HENRY L. HARRELL, M.D.
Ocala, Fla.

Attention is called to the next to last paragraph, to say vigorous Amen! to this. "Well begun, is half done," and it is the only way to find out for yourself. ◄

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Gleaned from the British Medical Journal

JACK W. HICKMAN, M.D.
Indianapolis

One of the first clinical reports of work with Indomethacin in the British literature appears in an article by Hart and Boardman.[1] This fascinating new compound was tested by the authors on 99 patients with various arthritides. The earlier reports on this compound indicated that it might be the first new non-steroid anti-inflammatory agent that we have had for such patients. The authors tested the drug in patients suffering from gout, ankylosing spondylitis, osteoarthritis and rheumatoid arthritis. Their studies confirmed the fact that this compound has anti-inflammatory actions as well as pain relieving effects in a high number of patients treated. While it is true that its anti-inflammatory benefits are less than those of the corticosteroids, it has many potential benefits in being a non-steroid agent. An extremely high percentage of side effects were noted in dosage ranges of 300 milligrams a day. At a lower dosage range of 200 milligrams a day, headaches and dizziness were still a very frequent side effect, and this may hamper any extensive clinical use of the drug. The authors found it effective in all the clinical conditions tested, and it will be extremely interesting to see whether Indomethacin or, more likely, compounds related to it develop into as valuable agents as they now appear to be.

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Although complete heart block is seen fairly frequently in clinical practice, the exact etiology of it is not easily pinned down. The usual tendency is to attribute it to coronary atherosclerosis without a full investigation of the situation. The present report by Zoob and Smith[2] is another of the investigations attempting to make more definitive diagnoses in patients suffering from complete heart block. The authors report a series of 51 cases, and in 43 of them the diagnosis of arteriosclerotic heart disease was made and incriminated as the cause of the heart block. This is one of the highest percentages of cases attributable to arteriosclerotic heart disease; previous figures have run in the neighborhood of 40% to 60% due to this condition. The other interesting finding is that the authors attributed none of their cases to hypertension, whereas previous studies have reported up to 24% as having hypertension as the likely cause for the heart block. It is extremely difficult to evaluate the actual results of this study since only seven of the cases were presented in any detail; however, most workers in this field would agree that arteriosclerotic heart disease is certainly the most common cause of complete heart block encountered in clinical practice.

* * *

Two reports of accidental loss of plastic tubes into the venous system are found back to back.[3,4] Unfortunately, this condition has occurred often enough that all physicians using these in-dwelling intravenous polythene catheters should be aware of this complication. Those of us in this area should be particularly aware of this difficulty because of the work of Taylor and Rutherford.[5] They point out the high morbidity and mortality associated with the loss of catheters into the general circulation. Fortunately, in both of the present cases, the patients recovered satisfactorily without

any serious complications; however, the follow-up time is not given in either presentation. The main difficulty in these cases seems to be that the polythene tube is sheared off by the sharp edge of the needle, and this is prone to happen if both the needle and the tubing are not adequately secured after induction of the catheter.

* * *

Although we hear less about therapy for hypercholesterolemia and its relation to coronary atherosclerosis, the present report by Watson[6] shows that some investigative work is still done in this line and that diets that are low in animal fat with supplemental feedings of corn oil are effective in lowering serum cholesterol over a long-term study. The present study consists of 28 patients who were followed up to four years on the program mentioned, and at the end of this time the patients showed a reduction of cholesterol of 15% to 25% and were able to follow the dietary program without any great difficulty. The author concludes that this program is feasible for long-term management of these patients, and that it is safe, acceptable, and has virtually no clinical contraindications. The only remaining question to be answered, of course, is whether it is effective in the prevention of coronary atherosclerosis. Evidence is obviously contradictory on this very important question.

* * *

Although the feeling has been that at times after pituitary ablation the gland was not, in fact, completely destroyed, it was not until the advent of the SU 4885 (metapyrone) test that a real evaluation of what the pituitary-adrenal axis is doing was possible. The paper by Sprunt et al.[7] reports on 17 patients who had Yttrium-90 pituitary implants done and were then evaluated with the metapyrone test in a standard manner. As might have been suspected, nine of the 17 patients showed definite evidence of residual pituitary activity after implantation. The authors also measured urinary gonadotrophins on all 17 patients and found that only three of the 17 patients showed significant levels of urinary gonadotrophins. The conclusions to be drawn from this study are that the metapyrone test is a more accurate measurement of pituitary function than the urinary gonadotrophins and also that we are not as effective in pituitary ablation as we think, or would like to think, that we are.

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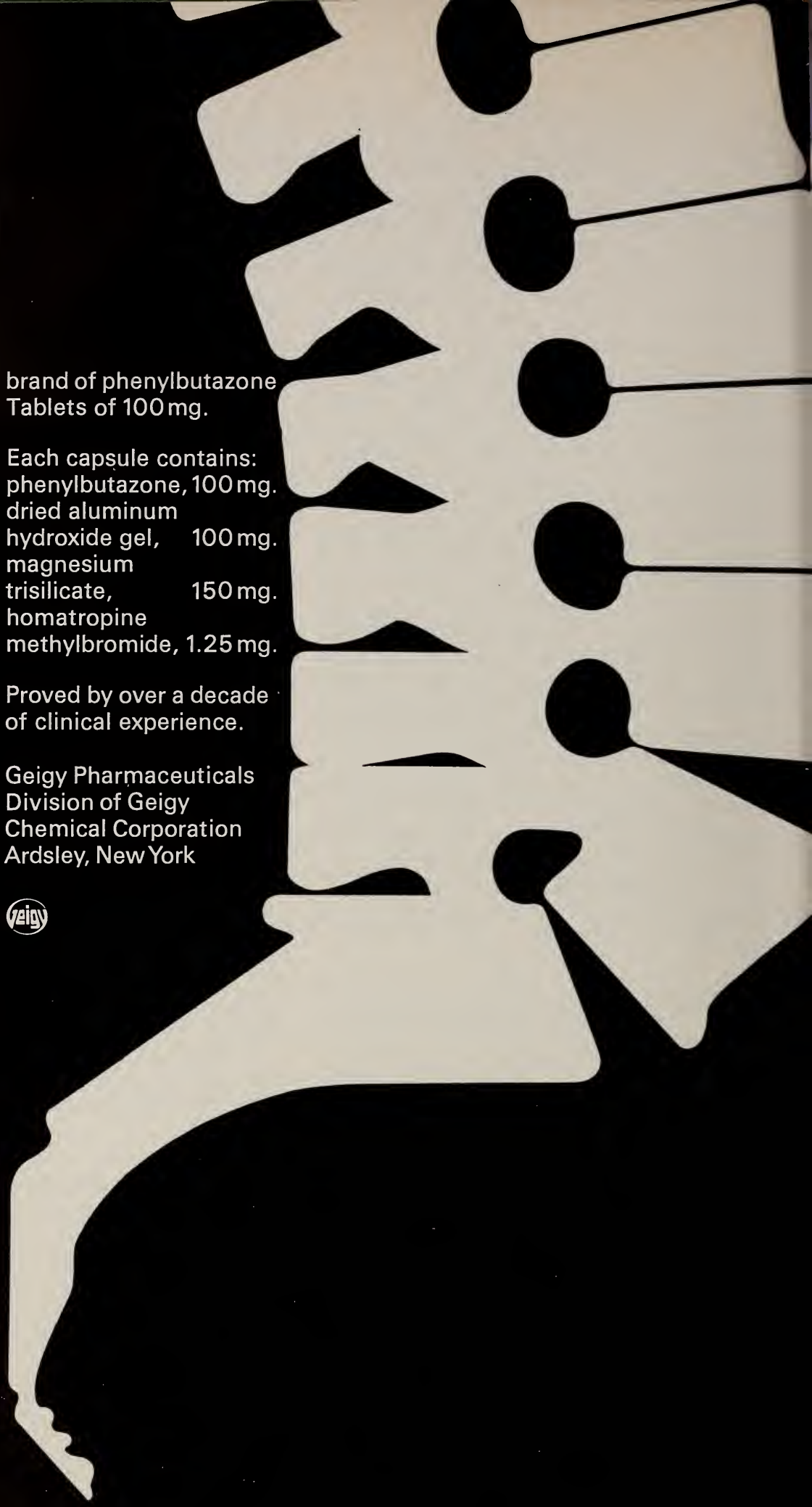
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Medicine At Law

DECISIONS AND OPINIONS

Highlights of recent court actions pertaining to health and medicine from *The Citation* prepared by the Law Division of AMA.

No Review Granted of Hill-Burton "Separate but Equal" Decision—By declining to review a decision which held the "separate but equal" provisions of the Hill-Burton Act unconstitutional, the U.S. Supreme Court allowed that decision to remain in force without approval or disapproval. This action by the court does not establish any precedent binding in other cases. The court, in denying review, issued no opinion.

The provision of the act which permits approval of state plans which include hospitals operated on a segregated basis if equivalent facilities are available to other population groups was held unconstitutional by the U.S. Court of Appeals for the Fourth Circuit in *Simkins v. Moses H. Cone Hospital,* 323 F. 2nd 959. In the suit, Negro physicians, dentists, and laymen sought to enjoin two hospitals from discriminating on the basis of race in the admission of patients and in hospital staff memberships. In order to reach a decision, this intermediate appellate court found that the Hill-Burton arrangement established an involvement of federal and state governments and that the activities of the private hospitals became activities of these governments.

Simkins v. Moses H. Cone Hospital,— Sup. Ct.— (U.S., March 2, 1964)

> *Citation Editor's Note*: Although the elimination of racial restrictions in the area of health care may be applauded, it is most regrettable that this should occur in a decision which holds that the operation of private hospitals becomes governmental activity merely because the hospitals receive financial assistance under a federal grant-in-aid program. It is also regrettable that the U.S. Supreme Court did not see fit to consider the important legal issues raised in this case.

Duodenal Ulcer Held Caused by Work Incidents—In a Workmen's Compensation case the evidence, including opinion testimony of a medical expert, was held sufficient to support a claim that a duodenal ulcer was precipitated by a series of work incidents suffered by an employee in the course of his employment. The claimant, an employee of an airline, wrenched his right arm and shoulder when a hangar door stopped suddenly. About two weeks later, a friend grabbed the claimant's arm and the claimant trying to get loose suffered an exacerbation to the right shoulder and neck.

About three months later, the claimant underwent surgery for the removal of his gallbladder and appendix. Two and one-half months later he slipped on an oil slick and suffered a hernia, which was surgically repaired. Following apparent recovery from this surgery, the claimant approached the premises of his employer while employees were on strike. He was blackjacked by some of the striking employees picketing the employer. This caused him to receive treatment for neck complaints. Approximately one year and a half later, he was hospitalized because of further neck complaints and at this time it was discovered that he also had a duodenal ulcer.

Hughes v. Eastern Air Lines, 155 So. 2d 135 (Fla., Nov. 13, 1962; rehearing denied, July 29, 1963)

Doctor Not Negligent in Performance of Nasal Operation—A patient was not en-

titled to recover damages from a doctor for a perforation which occurred during the performance of a nasal operation, a New York trial court ruled.

The only evidence offered by the patient in support of her claim that the doctor was negligent in his performance of a nasal operation, because a perforation occurred during the operation, was the testimony of an expert witness, a surgeon. Although this expert witness did not know the procedures followed by the doctor in performing the operation, he testified to the effect "that if the operating physician operated correctly, he would not have obtained a perforation." To hold that the result of an operation proved malpractice would be to enunciate a dangerous doctrine, the court said. Such a doctrine would be dangerous because it would result in all sorts of unsupported claims against doctors and would make it practically impossible for a doctor to rebut a claim of malpractice. Medicine would be without any recourse against charlatans and those seeking redress of fancied grievances, the court said.

Marrero v. Manhattan Eye, Ear and Throat Hospital, 150 (109) N.Y. Law Journal 14 (Sup. Ct., N.Y. Co., Dec. 5, 1963)

Workmen's Compensation Benefits for Traumatic Neurosis Denied—An employee was not entitled to benefits, under the Workmen's Compensation Act, for total and permanent disability due to traumatic neurosis resulting from accidental injuries. He failed to sustain his burden of proving he suffered from traumatic neurosis, a Louisiana intermediate appellate court ruled. In so ruling, the court reversed the judgment of a trial court and dismissed the employee's action.

The employee was paid Workmen's Compensation benefits when he injured his left side and wrist in a fall from a scaffold. He then sought total and permanent disability benefits claiming he was suffering from traumatic neurosis caused by his injuries.

It is now well established that Workmen's Compensation benefits may be recovered for disability arising from traumatic neurosis. However, a court must proceed in such cases with utmost caution and exercise extreme care because of such a condition's nebulous characteristics, the court said. The employee must establish his claim to a legal certainty and by a reasonable preponderance of the evidence. The testimony of a psychiatrist, who was the employee's only witness, was not sufficient to meet this standard, the court ruled. His testimony as to whether the employee actually suffered traumatic neurosis was vague and unconvincing and, in some instances, contradictory. The psychiatrist's conclusions were based on subjective symptoms related by the employee in two interviews six days apart, each lasting less than an hour, and conducted some 16 months after the accident. Under these circumstances, his testimony was insufficient to establish to a legal certainty a case of traumatic neurosis.

Elliott v. Insurance Company of North America, 159 So.2nd 313 (La., Dec. 6, 1963; rehearing denied Jan. 9, 1964)

Medical School Faculty Members Not Entitled to Payments from Medical-Service Plan—Full-time salaried teachers at a medical school could not collect payment from a medical-service plan for professional services rendered by them to patients in a city hospital. Their claim for payment was rejected by a New York trial court.

By agreement between the city and the medical school, the teachers served on a rotating basis as the visiting staff of the city hospital. They served without compensation, were assigned to make rounds in various wards, and were not permitted by local law to charge patients fees for the services rendered.

The court held that the teacher-physicians were not entitled to payment from the medical-service plan for services to patients covered by the plan, since the patients were not obligated to pay for the services. The court also held that there was no personal physician-patient relationship, since a new staff of physicians from the faculty was assigned to the hospital each month.

Sheinberg v. United Medical Service, N.Y. Sup. Ct., N.Y. Co. (N.Y.L.J., Jan. 13, 1964)◄

1963 Record Year for Indiana Blue Shield

(One of a series prepared by Blue Cross-Blue Shield)

During 1963, Indiana Blue Shield established new highs in membership, in the number receiving benefits and in the value of benefits provided. Year-end figures also reveal that 1963 was our best year to date in terms of low-cost operating efficiency, protection for the 65 and over and broader benefits.

As of December 31, 1963, Blue Shield membership in Indiana was the largest ever. At the end of the year, we were protecting 1,491,827 persons, and the net gain for the year was 22,157 members.

During the year we paid out a larger amount than we had in any one year since the plan was organized. The payout total was $23,319,855. The comparable 1962 total was $20,721,436.

The number of claims also hit an all time high, totaling 662,710 for the year. The number of claims paid in 1962 was 587,213.

Indiana Blue Shield since organization in 1946 has now paid a grand total of more than $165 million to our members for physicians' services.

The Blue Shield and Blue Cross combined payment to doctors and hospitals since the two Indiana plans were organized totaled more than $600 million at year end.

Our expense of doing business on the basis of percentage of income continued to decrease, and in 1963 amounted to only 6.8% of income.

Income from membership fees increased from $23,192,565 in 1962 to $25,224,030 in 1963.

Our program of selling broader benefit plans to our members continued to show substantial gains. At the end of 1963, 57% of our membership was enrolled under the preferred or special programs. In 1960, only 37% were protected by the broader coverages. Some 94% of our members now have in-hospital medical benefits. Three years ago that figure was 90%. In 1960, 31% of our account members had diagnostic x-ray and pathology benefits. Today, the comparable figure is 62%.

Our program for the 65 and over includes developing benefits that match their needs in terms of medical practice in Indiana today, and actively selling this protection to the aged at a price most of them can afford to pay. The success of the special effort made for this group is indicated by the fact that presently more than 154,000 persons 65 and over are voluntarily enjoying the security of membership in the Indiana plans. That's more than one-third of our aged population. Last year the comparable total was 150,000.

Blue Cross and Blue Shield will continue to operate on a community service basis. Both plans have faith in the voluntary system and believe that this type of operation has proved by performance to be the best solution to the problem of financing health care for the community as a whole.

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The Journal Welcomes New ISMA Members

Charles F. Abell, M.D., *Ob-Gyn,* Jefferson Medical College, 1956. (Grant)

C. Dane Breedlove, M.D., *General Practice,* Indiana University, 1957. (Grant)

Donald D. Cheesman, M.D., *General Practice,* Indiana University, 1960. (Hendricks)

John F. Cochran, M.D., *Student Health Medicine,* University of Pittsburgh, 1948, (Owen-Monroe)

Melvin D. Cook, M.D., *General Surgery,* University of Nebraska, 1956. (Floyd)

Hanus J. Grosz, M.D., *Psychiatry,* Welsh National School of Medicine, Gt. Britain, 1953. (Marion)

Harry J. Halikiopoulos, M.D., *Urology,* Aristotle University of Salonika, Greece, 1956. (Lake)

Herbert P. Hargett, M.D., *Ophthalmology,* University of Louisville, 1943. (Clark)

George J. Heid, Jr., M.D., *Pathology,* University of Pittsburgh, 1939. (Tippecanoe)

Robert D. Johnson, M.D., *General Practice,* Indiana University, 1960. (Jefferson-Switzerland)

James L. Kaiser, M.D., *Orthopedic Surgery,* Indiana University, 1955. (Marion)

Edgar Kourany, M.D., *General Practice,* Indiana University, 1962. (Morgan)

Oscar Kourany, M.D., *General Practice,* Indiana University, 1962. (Morgan)

Henry B. Larzelere, M.D., *General Surgery,* Northwestern University, 1943. (Grant)

Heracleo Matheu, M.D., *Psychiatry,* Santo Thomas University, Philippines, 1942. (Cass)

Richard C. McPherson, M.D., *General Surgery,* Ohio State University, 1954. (Tippecanoe) ◄

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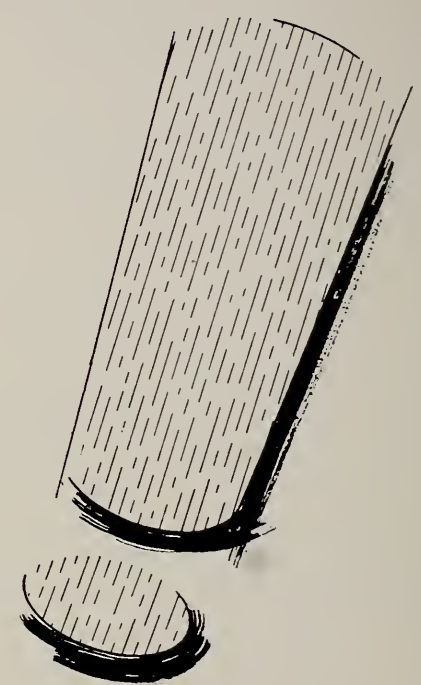
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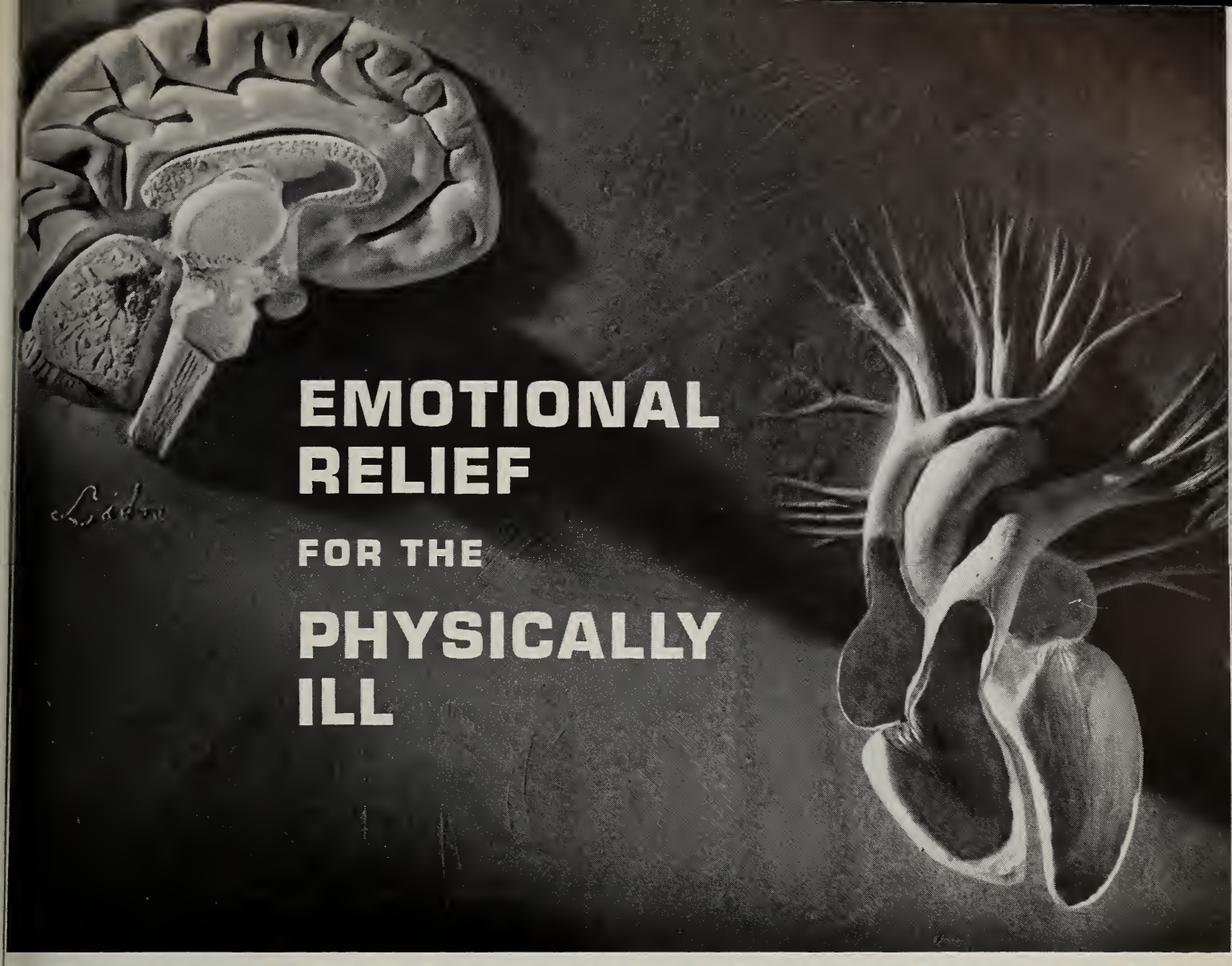
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BOOK REVIEWS

TRANSPLANTATION

Ciba Foundation Symposium, Nov., 1961—edited by G. E. Wolstenholme and M. P. Cameron. Little, Brown & Co., Boston, Mass. 426 pages, numerous tables and illustrations. $12.00.

Under the distinguished chairmanship of Nobel prize winner Professor Medawar, some thirty experts in this rapidly developing subject bring the reader (and themselves) up to date on topics still esoteric but soon to be intensely practical.

Whether "homografts" should be called "allogeneic" and "heterografts" "xenogeneic" is semantics only. But the HOW of making organ transplants stay viable in the recipient is a transcendentally practical problem that is even now trembling on the brink of a positive answer.

In this symposium, a good deal of expert knowledge is taken for granted as the participants explore in depth such topics as tolerance, paralysis, thymus role in utero and in infancy—irradiated chimeras—"white" grafts—inciting antigens:—many other exotic (as yet) fields of knowledge.

It might be useful to read a recent textbook dealing with these matters before plunging into *Transplantation.* I might suggest the very excellent chapter on "Immune Mechanisms" by Elvin Kabat in the 11th edition of Cecil & Loeb (p. 450 on). The format is excellent, presentation first class and the entire volume seemed to me eminently worth the effort of reading.

For the surgeon who wants to be abreast of the next great medical breakthrough, for the family practitioner willing to do some hard reading, for ALL medical and paramedical personnel desirous of understanding the *how* of scientific progress: well, this is a book to buy, to read, to re-read—and then to start from the beginning yet again!

ARNOLD LIEBERMAN, M.D.
New York, N. Y.

TEXTBOOK OF ORAL PATHOLOGY

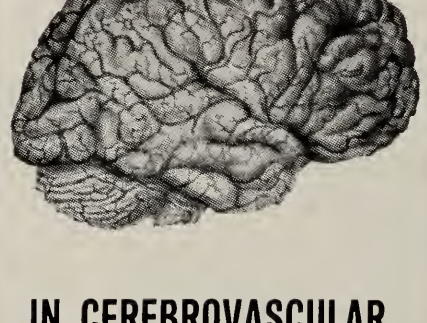
William G. Shafer, D.D.S., Maynard K. Hine, D.D.S., Barnet M. Levy, D.D.S., W. B. Saunders Company, Philadelphia, Pa., June, 1963. Second edition, illustrated, 516 figures, 768 pages, $17.00.

The authors seem to have the knack of making cumbersome material appear light; they simplify while giving clear discussions of vast quantities of information. The illustrations are plentiful and well chosen to clinch the point being presented.

Basic information of immense value is given in such a clear manner that the dental student, general practitioner and dental specialist can all benefit. The sum total of the five sections en-

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compasses the entire field of Oral Pathology. The authors succeed very well in their avowed aim of explaining oral diseases by, "the application and integration of histologic, chemical and physiological alterations of basic biological processes."

To keep abreast of the demands of complete health care in modern dentistry, one has to consider the local and systemic aspects of oral disease. The format is excellent, printing clear, price, reasonable. There is no better book in its field; it is a *must* for the entire dental profession.

ARNOLD LIEBERMAN, M.D.
New York, N. Y.

Abstracts From Various Literature, Prepared by AMA

TERMINATION OF DIETARY TREATMENT FOR PHENYLKETONURIA

Vandeman, P. R.: Termination of Dietary Treatment for Phenylketonuria, *Amer. J. Dis. Child.* 106:492 (Nov.), 1963.

Two patients with phenylketonuria were treated with phenylalanine deficient diets from the ages of five months and one month. Treatment was terminated at the age of three years, and developmental follow-up showed no evidence of deterioration through the ages of 6½ and 7½ years. It would appear that dietary treatment for phenylketonuric patients (treated from an early age) may be terminated at an age of about three to four years with relatively little risk of further damage to mental development.

THE FATE OF OLFACTION AFTER LARYNGECTOMY

F. N. Ritter (Univ. of Michigan, Ann Arbor, Mich.) *Arch. Otolaryng.* 79:169 (Feb.) 1964.

Since the nose is no longer used in respiration following laryngectomy, changes occur in the color and histological architecture of the mucosa. To determine whether the nasal olfactory epithelium also undergoes alterations, the sense of smell was tested in ten laryngectomized patients. The findings showed that the power of olfaction did not change in these patients. The assumption is, therefore, that neurological changes in the terminal endings in this special sense do not occur after laryngectomy.

CYTOLOGY PROGRAM IN BRITISH COLUMBIA: III. MANAGEMENT OF PRECLINICAL CARCINOMA OF THE CERVIX

F. E. Bryans (2098 W. 46th Ave., Vancouver, BC), D. A. Boyes, J. R. Boyd, H. K. Fidler, *Canad. Med. Ass. J.* 90:62 (Jan. 11) 1964.

Between the years 1949 and 1961, 200,509 wom-



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Continued

en were examined by routine cervical cytology in the province of British Columbia. A cone biopsy is done when cytology is suspicious or positive, because the authors believe that the proper management can only be planned after step serial sections of an adequate cone biopsy. If the cone biopsy shows in situ carcinoma or microscopic foci of invasion, a total hysterectomy is carried out in most cases. If occult but fully confluent invasion is present, radiotherapy is used. Of 1,177 cases of preclinical carcinoma found in this study, 1,051 were purely in situ carcinomas, 73 showed in addition microscopic foci of invasion, and 53 showed confluent active invasion but had not produced a clinical lesion. The mean age studies of the different groups of preclinical carcinoma support the contention that all are sequential stages of a single disease process. The only cases with recurrent disease or mortality have been in the occult invasive group.

HYPOGAMMAGLOBULINEMIA PRESENTING AS PSEUDOMONAS SEPTICEMIA

Spiers, C. F., Selwyn, S., Nicholson, D. N.: Hypogammaglobulinemia Presenting as Pseudomonas Septicemia, *Lancet* (London) 2:710 (Oct. 5), 1963.

A previously healthy 11-month-old boy was admitted to a hospital with septicemia due to *Pseudomonas pyocyanea* (*aeruginosa*). There were no obvious predisposing factors such as hospitalization or long-term antibiotic, antimitotic, or steroid therapy. Instead, primary hypogammaglobulinemia was discovered and the patient was found to be an intestinal carrier of *Ps pyocyanea. A Pseudomonas* pustule—the probable site of invasion—was located on the patient's thigh and developed the features of ecthyma gangraenosum. Treatment was successfully carried out with chloramphenicol and colistimethate sodium (colistin methanesulfonate). Gamma globulin therapy was started later. A younger sister of the boy was later found to have apparent hypogammaglobulinemia.

THE CONIZATION-HYSTERECTOMY TIME INTERVAL

L. R. Malinak (Hermann Hosp., Houston), R. A. Jeffrey, Jr., W. J. Dunn, *Obstet. Gynec.* 23:317 (March) 1964

In a clinical and pathological study of 124 consecutive patients who underwent hysterectomy following conization of the cervix, it was found that the posthysterectomy morbidity—due to dissemination of infection in and about the cervix—was greatly increased if the hysterectomy had been performed within three weeks of conization. In a similar review, the cryostat frozen section technic, for study of conization specimens so that hysterectomy can be performed immediately after diagnosis, was found to aid in the circumvention of this morbidity. ◄

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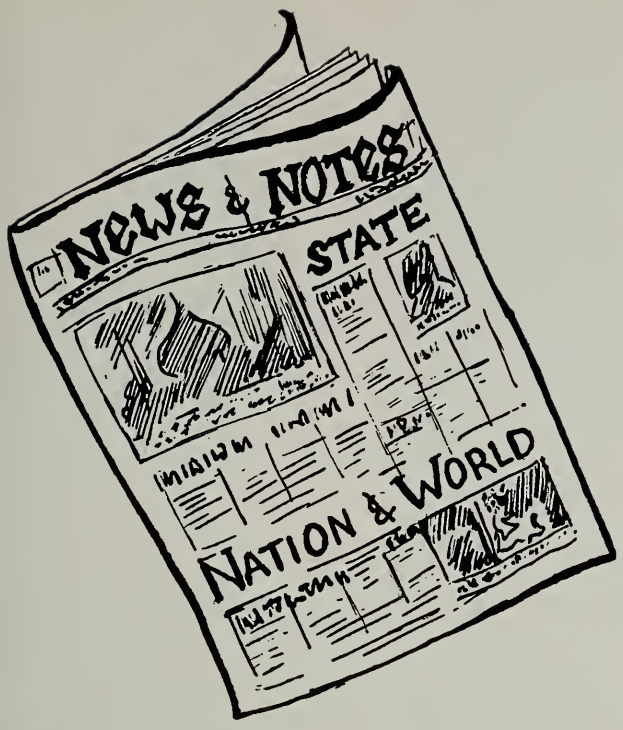
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SEARCHING, SCREENING COMMITTEE TO AID IN FILLING DEANSHIP OF I. U. SCHOOL OF MEDICINE

A searching and screening committee for the purpose of assisting the President and the Trustees of Indiana University in filling the deanship of the School of Medicine has been appointed by President Elvis J. Stahr.

The committee has been asked to present not less than three names of persons believed to be highly qualified. The committee will establish its own procedures and is expected to receive suggestions and evaluations from the faculty of the School of Medicine as well as from other sources outside the school.

"We want to locate and bring to the leadership of the School of Medicine the best available man for the task," President Stahr said in announcing the membership of the search and screening group.

Members are: Professor James E. Ashmore, Chairman, Pharmacology, and Professor of Biochemistry and Pharmacology; Professor Parker R. Beamer, Chairman and Professor of Pathology, and Director of Clinical Correlation and Research; Dr. Joseph M. Black of Seymour, president-elect of the Indiana State Medical Association and a graduate of the Indiana University School of Medicine; Professor William R. Breneman, Luther Dana Waterman Professor of Zoology, College of Arts and Sciences; Professor John B. Hickam, Chairman and Professor of Medicine; Dean Maynard K. Hine, School of Dentistry; Dean Emily Holmquist, School of Nursing; Dean John J. Mahoney, Associate Dean of the School of Medicine and Associate Professor of Experimental Medicine; Professor James O. Ritchey, Distinguished Service Professor of Medicine Emeritus; and Professor Harris B. Shumacker, Jr., Chairman and Professor of Surgery. Dr. Mahoney is chairman of the committee and Dr. Ritchey is vice-chairman.

Dr. Verne K. Harvey to Retire

Dr. Verne K. Harvey, director of the two Indianapolis Veterans Administration Hospitals, will retire this month.

Dr. Harvey has served as head of the Cold Springs Road and West 10th Street Hospitals since 1958 and has been in government service 25 years.

A graduate of the I. U. School of Medicine, Dr. Harvey served his internship at General Hospital. He also has a master's degree in public health from Johns Hopkins University.

Industrial Medicine Data Needed by Dr. Painter

Dr. Lowell Painter, Winchester, is interested in collecting suggestions and advice for an ISMA booklet which would be helpful to the general practitioner who is called upon to practice part-time industrial medicine.

Any member of ISMA experienced in this field, is invited to write Dr. Painter at 124 E. Franklin St., Winchester, Indiana.

Invitation to Golfing Physicians

The Indiana Society of Medical Service Representatives invites all physicians who enjoy golf to join with them in the third annual 500 Golf Preview Golf Classic May 20 at the Ulen Country Club in Lebanon.

Trophies and prizes will be awarded and the winner of a special hole-in-one contest will win $100.00 in gift certificates. For further information contact Herschell Lammey, 2902 N. Meridian St., or phone WA 6-1569.

Medical Library of the American College of Surgeons is Dispersed

The medical library of the American College of Surgeons has been dispersed and except for remaining items of historical significance, has been given to seven new medical schools. Some 12,345 volumes of scientific journals and 752 textbooks were donated to the University of Arizona, Brown University, Albert Einstein College of Medicine, University of Kentucky, University of New Mexico, Seton Hall College of Medicine and Dentistry and West Virginia University.

The college library, located in the new headquarters building at 55 E. Erie St., Chicago, will be devoted to rare historical volumes. There are more than 2,300 items in the collection, some books printed as early as 1508.

Continued

American Medical Association Elects Six Indiana Physicians

Six Indiana physicians have been appointed to councils, committees and subcommittees of the American Medical Association.

Dr. Norman R. Booher, Indianapolis, has been appointed a member of the AMA Council on Voluntary Health Agencies.

Other physicians named include: Dr. Eli S. Jones, Hammond, elected chairman of the Council on Occupational Health and re-appointed a member of the Committee on Mental Health in Industry; Dr. Donald E. Wood, Indianapolis, re-appointed a member of the Council on Legislative Activities; Dr. John B. Hickam, Indianapolis, re-appointed a member of the Council on Postgraduate Programs; Dr. C. G. Culbertson, Indianapolis, re-appointed a member of the Committee on Blood and Dr. Willard S. Krabill, Goshen, re-appointed a member of the Committee on Medicine and Religion.

R. N. Harger, Ph.D. of Indianapolis, has been re-appointed a member of the Subcommittee on Chemical Tests for Intoxication of the Committee on Medico-legal Problems.

Dr. Bibler Participates in Conference

Lester D. Bibler, M.D., participated in a Family Practice Curriculum Conference at the University of Kentucky Medical Center, Lexington, Kentucky the latter part of March.

Ames Company Presenting An Exhibit at N. Y. World's Fair

The Ames Company, of Elkhart, is presenting an exhibit on "Diagnosis of Disease" in the Hall of Science at the New York World's Fair.

The Ames Company's exhibit will show the history and future of diagnosis as it relates to body chemistry. The walk-in exhibit will be divided into several areas containing visual aids augmented by an audio system providing discussion of the areas covered.

One portion of the exhibit will be an animated diagram of the human circulatory system showing the transport and filtration of chemicals through the blood and kidneys. Emphasis will be placed on the digestive system, liver, heart and kidneys, explaining their role in maintaining the body's vital chemical balance. A second exhibit area will consist of a number of displays illustrating diagnosis of specific diseases, such as gout, diabetes and mental retardation. Chemical changes related to these diseases will demonstrate the importance of early diagnosis and treatment. The balance of the exhibit will predict future possibilities of chemical and electronic diagnosis and their effect on the practice of medicine.

Ames' exhibit has been developed to promote understanding of the goals and accomplishments of science as expressed in the continuing search for more useful methods for diagnosis of disease.

Status of G.P.'s is Topic of Accreditation Commission Statement

The following statement on the status of general practitioners appeared in the March issue of *The Bulletin of the Joint Commission on Accreditation of Hospitals*:

The Joint Commission on Accreditation of Hospitals believes that general practitioners should have the opportunity to practice medicine as active staff members in hospitals and should have granted to them hospital privileges as their training and demonstrated skills indicate. In order to implement this philosophy the Joint Commission:

(a) Reaffirms its position that where indicated and appropriate, general practice departments or sections should be established in hospitals.

(b) Recommends that the commissioners, staff, and surveyors of the Joint Commission speak to and urge hospital boards of trustees and medical staffs to earnestly consider the appointment of qualified general practitioners to the active staffs of hospitals.

(c) Requests the American Medical Association and the American Hospital Association to utilize whatever means they have available to promote among their membership this principle, namely, that general practitioners should be appointed to the active medical staffs of hospitals and should be granted such hospital privileges as their training and demonstrated skills warrant.

It is realized that the Joint Commission cannot require a hospital to take a physician onto its medical staff. This is solely the prerogative of the hospital. However, the commissioners do heartily recommend and endorse the above principles.

Dr. Kilgore Addresses Group

Dr. Byron Kilgore addressed the Pastoral Clinical Training Workshop held at Parkview Hospital in Fort Wayne in March under the direction of Pastor Stoop. The topic of his lecture was "Assisting the Pastoral Counselor in the Recognition and Referral of Persons With Psychiatric Problems."

Psychiatry Society Elects Officers

Dr. August J. Dian, Gary, has been elected president of the Northern Indiana Psychiatry Society.

Other newly elected officers include: Drs. L. D. Borough, South Bend, president-elect; Hans Meyer, Westville, vice-president; R. L. Shriner, South Bend, treasurer; J. R. Matthew, Westville, secretary; Theodore Hill, South Bend, councilor; Grant E. Metcalfe, South Bend, delegate and John U. Keating, Elkhart, alternate.

Dr. Campbell on AMA Panel

John A. Campbell, M.D., of Indianapolis will

Continued



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be a participant in the program covering cardiovascular opacification and surgical therapy which will take place at the 113th AMA Annual Convention. The program will be moderated by Michael E. De Bakey, M.D.

Dr. Campbell, who was graduated from the University of Cincinnati in 1937, is chairman of the Department of Radiology at I. U. Medical Center.

Dr. Babcock Resigns Directorship

Dr. Kenneth B. Babcock has resigned as director of the Joint Commission on Accreditation of Hospitals, effective October 1. Dr. Babcock has served as director since 1954 when he took over from Dr. Edwin Crosby, the original director. Dr. Babcock expects to live in Florida and do hospital consulting work, emphasizing assistance to hospitals seeking to get or maintain accreditation.

General Practice Academy Elects

Dr. A. Alan Fischer, Indianapolis, has been elected president of the Indiana Academy of General Practice.

Also elected were: Drs. James W. Crain, Williamsport, president-elect; Joseph J. Sala, Gary, vice-president and Jerome E. Holman, Jr., Indianapolis, treasurer.

New Parliamentary Procedure Chart

A new authoritative chart on Parliamentary Procedure had been published by Dr. George Schmitt as an easy reference for speakers and other presiding officers.

A copy may be obtained by sending five cents in coin (no stamps please) to Dr. George F. Schmitt, 30 S. E. Eighth St., Miami, Florida.

New Nursing Home Accredited

The National Council for the Accreditation of Nursing Homes has accredited a new home in South Bend.

The nursing home, containing 56 beds, is called the Cardinal Convalescent Center, Inc.

R. S. Saylor Appointed to Post

R. S. Saylor, executive vice-president of Indiana Blue Shield, has been appointed a member of the executive committee of the National Association of Blue Shield Plans.

Mr. Saylor is a member of the board of directors of the national association, and a member of the joint operating committee of Medical Indemnity of America, Inc., and Health Service, Inc.

Apologia

Due to a typographical error, the name of Dr. J. R. Frank, Valparaiso, was misspelled in the County, District News column of the March issue of *The Journal*. We regret any embarrassment caused by the error.

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Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
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FUTURE MEETINGS, SEMINARS, COURSES

Society of Nuclear Medicine Sets 11th Annual Meeting in June

The Society of Nuclear Medicine, an international organization comprised of physicians, chemists, physicists, biologists and other scientists will hold its 11th annual meeting in the Claremont Hotel, Berkeley, California, June 17-20.

The scientific program will include a series of refresher courses to be presented at 7:30 each morning. Many original papers dealing with the diagnostic, therapeutic, preclinical and radiobiological aspects of nuclear medicine will be presented during the three day meeting. In addition to the original presentations, there will be four panel discussions dealing with side effects, diagnostic advances, space and volumes and therapeutic advances.

Programs and additional information may be obtained by writing to Mr. Samuel N. Turiel, Administrator, Society of Nuclear Medicine, 333 N. Michigan Ave., Chicago, Illinois 60601.

ISMA Members Invited to Seminar On Diabetes and Related Disorders

The Florida Diabetes Association will conduct its annual seminar on Diabetes and Related Endocrine Disorders from September 30 to October 2 at the Balmoral Hotel in Miami Beach. Members of ISMA are invited to attend. The registration fee is $20.00.

Further details and a copy of the program may be obtained by writing Dr. George Schmitt, 30 S. E. Eighth St., Miami, Florida.

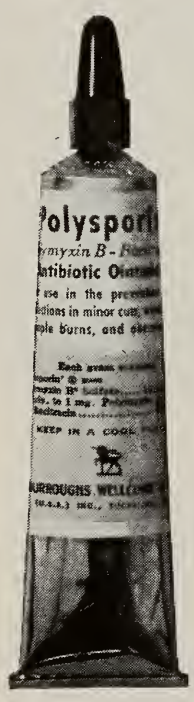
Sixth Workshop on Problems of Alcoholism Set June 9-19 at I.U.

The sixth workshop on the Problems of Alcoholism and Alcohol Education will be held June 9-19 on the Bloomington campus of Indiana University.

The workshop is planned especially for teachers, social and welfare workers, nurses, medical personnel, industrial and community leaders, clergymen and others interested in alcoholism, one of the nation's most serious health problems.

Tuition is $22.00 for the full course, payable upon registration. For further information, contact J. K. Rash, Chairman, Department of Health and Safety, School of Health, Physical Education and Recreation, Indiana University, Bloomington.◄

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Frank Gross, 185-01 Hillside Ave., - Apt. 1-M, Jamaica, N. Y.

Vernon S. Kent, 1795 B. Northwest Court, Columbus, Ohio.

Ted L. Megremis, 16155 Champaign Rd., Allen Park, Mich.

Edward Serrano, Carrera 8 # 19-25, Bogata, Colombia, South America.

Marilyn Wagoner, 357 Behm Dr., Grayslake, Illinois

Don J. Wagoner, 357 Behm Dr. Grayslake, Illinois (Husband and wife team; applications to be considered together.)

SPECIALISTS

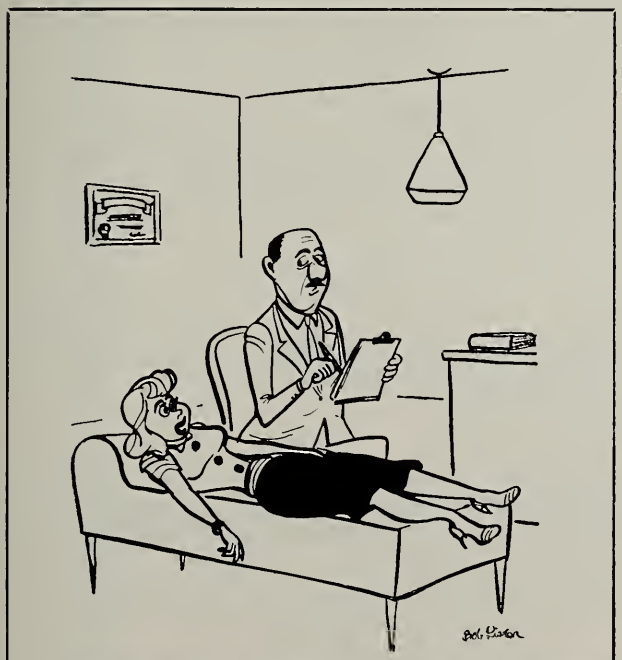
James F. Hora (Major, MC USA) 681-A Infantry Post, Ft. Sam Houston, Texas—*Ear, Nose & Throat*

Ralph O. Hayden, 5249 Olentangy Dr., Dayton, Ohio, 45431—*Internal Medicine*

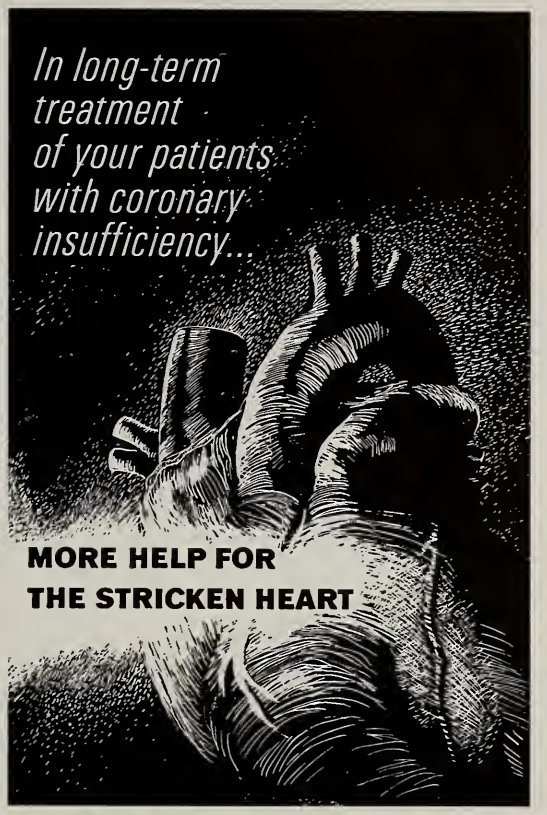
Joe L. Hughes, Cardinal Hill Hospital, Versailles Rd., Lexington, Ky.—*Orthopedics*

Arthur B. Bradsher, 1200 Broad St., Durham, North Carolina—*General, Thoracic and Traumatic Surgery and Aviation Medicine*

Dean R. Bahler, 104 Mohawk Lane, West Lafayette, Ind.—*College Health, Administrative Teaching and Practice* ◄



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County News

Allen

Dr. George C. Morris, Jr., associate professor of surgery at Baylor University, Houston, Texas, was guest speaker at the April 7 meeting of the Allen County Medical Society. His topic was "Surgical Treatment of Arteriosclerotic Diseases."

Benton

Dr. Avery L. Coddens, Earl Park, will serve as president and Dr. Donald L. McKinney, Otterbein, secretary of the Benton County Medical Society.

Cass

The Cass County Medical Society met April 6 to hear Dr. Paul Wilson report on a postgraduate course on aortography which he recently completed at Cook County Hospital. There were 24 members present.

Elkhart

The new president of the Elkhart County Medical Society is Dr. Frederick W. Bigler, Goshen. Dr. Page E. Spray, Elkhart, will serve as secretary.

Fayette-Franklin

The Fayette-Franklin County Medical Society met April 14 to view a film entitled "Management of Vascular Complications of Diabetes."

Floyd

Dr. Kareem Minhas, professor of medicine and pediatrics at General Hospital, Louisville, Ky., spoke on "New Concepts of Heart Sounds" before the April 10 meeting of the Floyd County Medical Society. There were 27 members present.

Jay

"Shoulder Injuries" was the topic chosen by Dr. Leland Brown, Muncie, when he spoke before the April 1 meeting of the Jay County Medical Society.

Lake

Dr. Stewart T. Ginsberg, Indianapolis, discussed "Alcoholism" with the Lake County Medical Society at its April 8 meeting. There were 38 members and 30 wives present.

Lawrence

Field Secretary R. J. Amick visited the April 1 meeting of the Lawrence County Medical Society to report on the Washington situation and stress the necessary action at the county level.

Montgomery

Dr. Victor Hackney spoke on "Newer Therapy of Some Common Problems in Dermatology" at the April 16 meeting of the Montgomery County Medical Society.

Orange

The Orange County Medical Society met April 7 with Field Secretary Amick to discuss Kerr-Mills and King-Anderson legislation and suggested action by the county society.

Owen-Monroe

Dr. Anthony Pizzo has been elected president of the Owen-Monroe County Medical Society. Assisting him will be Drs. Joseph Milan, vice-president; William C. Link, secretary; Frank Hrisomalos, treasurer; Paul J. Wenzler and Frederick Smith, delegates and Joseph Milan and Oran Kay, alternates.

Parke-Vermillion

Newly elected officers of the Parke-Vermillion County Medical Society are: Drs. Robert M. Fell, president; Milton Beebe, vice-president; Frederick Evans, secretary-treasurer; Milton Beebe and John M. Kercheval, delegates and Richard Bloomer and Frederick Evans, alternates.

Putnam

The Putnam County Medical Society has elected the following officers for the coming year: Dr. Richard Veach, Bainbridge, president; Dr. V. Earle Wiseman, Greencastle, vice-president and Dr. Lawrence R. Jones, Greencastle, secretary-treasurer.

Shelby

Dr. P. M. Inlow, Shelbyville, gave a discussion on x-rays of unusual cases before the April 1 meeting of the Shelby County Medical Society.

Vanderburgh

Mr. Roger Zion, sales training director of Mead Johnson & Company, spoke at the April 14 meeting of the Vanderburgh County Medical Society. His topic was a political one.

Warrick

Dr. Peter B. Hoover is the newly elected president of the Warrick County Medical Society. Dr. Robert Terry was elected secretary-treasurer and Dr. Wendell C. Stover, delegate.

Washington

Newly elected president of the Washington County Medical Society is Dr. Charles B. Carty, Pekin. Dr. Thomas K. Tower, Campbellsburg, will serve as secretary-treasurer.

Wells

The Wells County Medical Society presented its fifth annual basic science lecture March 20. Speaker was Walter Block, Ph.D., biochemist at the University of Michigan. His topic was "A Biochemist looks at Coronary Artery Disease."

White

Members of the White County Medical Society met April 15 to view a film on "Peritoneal Dialysis" presented by Cutter Laboratories. ◄

Deaths

Robert E. Bishop, M.D.

Dr. Robert E. Bishop, 52, of Pierceton, died Feb. 16 in Chicago. A former member of the Wells County Medical Society, Dr. Bishop was a general practitioner in Pierceton from 1962, having moved there from Bluffton.

Howard V. Blosser, M.D.

Dr. Howard V. Blosser, general practitioner in Fort Wayne for almost 60 years, died Feb. 16. He was 91.

A member of the Allen County Medical Society and the ISMA 50-Year Club, Dr. Blosser began the practice of medicine in 1899 and moved to Fort Wayne in 1903.

William W. Kearney, M.D.

Dr. William W. Kearney, 51, a staff physician at New Castle State Hospital, died March 3 at the Veterans Administration Hospital in Indianapolis.

Dr. Kearney, a former member of the Delaware-Blackford County Medical Society, went to New Castle in 1962. He was a native of Dubuque, Iowa.

Carl B. McCord, M.D.

Dr. Carl B. McCord, 81-year-old general practitioner, was suffocated in a fire which destroyed the interior of his Veedersburg home March 5.

Dr. McCord, a 1908 graduate of the I.U. School of Medicine, was a member of the ISMA 50-Year Club and the Fountain-Warren County Medical Society.

Clyde R. Netherton, M.D.

Dr. Clyde R. Netherton, a Chalmers physician for 43 years, died March 2 at the age of 80.

Dr. Netherton, a 1913 graduate of the Chicago College of Medicine and Surgery, was White County coroner for eight years and Big Creek Township trustee for three years. He was a member of the 50-Year Club and the Tippecanoe County Medical Society.

Thomas R. Owens, M.D.

Dr. Thomas R. Owens, 72, a general practitioner at Muncie almost 50 years, died the latter part of February.

Dr. Owens was a Senior Member of ISMA and had been a delegate and member of many association committees. Dr. Owens was graduated from the University of Cincinnati in 1918, was on the staff of Ball Memorial Hospital for many years and was a member of the Delaware-Blackford County Medical Society.

Continued

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115th Annual Convention

INDIANA STATE

MEDICAL ASSOCIATION

October 12-15

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RESERVATIONS . . .

DEATHS

Continued

Karl S. Strickland, M.D.

Dr. Karl S. Strickland, 83, Gibson County health officer, died March 16 in an Evansville hospital.

A physician in Owensville and Princeton for 57 years, Dr. Strickland was graduated from the University of Louisville School of Medicine in 1907. He was a veteran of the Spanish-American War and World War I, was a member of the ISMA 50-Year Club and the Gibson County Medical Society.

Leslie Wilson, M.D.

Dr. Leslie Wilson, chief of surgery at the Fort Wayne Veterans Administration Hospital, died March 16. He was 63.

Dr. Wilson, a graduate of the I.U. School of Medicine in 1928, was a native of Longstreet, Ky., and had practiced in Fort Wayne for seven years. He was a member of the Allen County Medical Society.

Reuben O. Zierer, M.D.

Dr. Reuben O. Zierer, 63, medical staff member of the Indiana State Hospital for Chest Diseases at Rockville for the last seven years, died April 1.

Dr. Zierer had formerly practiced at Anderson and headed the medical defense unit at St. John's Hospital there. He was a member of the Parke-Vermillion County Medical Society. ◄

SCIENTIFIC EXHIBIT APPLICATION FORM

Committee on Scientific Exhibits
Indiana State Medical Association
3935 N. Meridian Street
Indianapolis 8, Indiana

Please send me an application form for a Scientific Exhibit at the ISMA Annual Convention, October 13-15, 1964, Murat Temple, Indianapolis, Indiana.

I propose to exhibit_____

Name_____

Address_____

City_____

State_____

Association News

EXECUTIVE COMMITTEE

March 25, 1964

Present: Ralph V. Everly, M.D., chairman; Don E. Wood, M.D.; Kenneth O. Neumann, M.D.; Irvin W. Wilkens, M.D.

Frank B. Ramsey, M.D., editor of *The Journal* and J. A. Waggener, executive secretary.

Membership Report:

Number of members as of December 31, 1963		4,371
1964 members as of February 29, 1964:		
Full dues paying	3,388	
Residents and interns	93	
Council remitted	33	
Senior	323	
Honorary	3	
Military	48	
Total 1964 members as of February 29, 1964		3,888
Number of members as of February 28, 1963		3,822
Gain over last year		66
Number of AMA members as of February 29, 1964		3,757
Total 1963 AMA members as of February 28, 1963		3,725
Gain over last year		32
1964 AMA members: Dues paying	3,258	
Exempt, but active	499	
	3,757	
Number who have paid state dues but not AMA dues as of February 29, 1964		131

Headquarters Office

The contract with Blue Cross-Blue Shield for the headquarters office employees was presented and renewal was authorized on motion of Drs. Neumann and Wilkens.

The secretary presented, for the committee's information, a study which had been made by another state on the dues of other state medical associations.

Building Matters

The chairman of the Building Committee discussed the acquisition of additional property and reported that the real estate agent had proposed that some disinterested person act on behalf of the association as purchaser. Upon motion of Drs. Neumann and Wood, Mr. Hollowell was authorized to act as agent for the association.

Treasurer's Office

The treasurer reported on the cash balances and the budgeted expenditures and his report was approved on motion of Drs. Wood and Neumann.

Legislation

The president reported on national and local legislation.

Organization Matters

The proposed changes in the Bylaws of the Woman's Auxiliary were read and were approved on motion of Drs. Neumann and Wilkens.

A letter from the State Board of Health concerning proposed changes in making grants to the State Board of Health for various projects was read and upon motion of Drs. Wood and Wilkens, the secretary was directed to write a letter to the effect that the association feels that local control of projects and distribution of funds is advisable.

Request of the LaPorte County Medical Society asking that one of their members who paid state dues after February 1 not be considered delinquent was approved on motion of Drs. Wood and Wilkens.

The committee was made aware of the suit which had been filed before the Insurance Commissioner of the State of Indiana by the Indiana State Podiatrists Association, Inc. against Mutual Medical Insurance, Inc.

A resolution from the South Carolina Medical Association concerning Interstate Mental Health Compacts and the opinion of Dr. S. T. Ginsberg, Mental Health Commissioner, were reviewed for the information of the committee. This resolution is expected to come before the American Medical Association House of Delegates in June.

A letter from the American Medical Association Education Research Foundation, in which the foundation transmitted $25,312.41 to Indiana University School of Medicine, was read for the information of the committee.

A letter from the Public Health Federation of Cincinnati, appealing for retention of the Taft environmental health center in Cincinnati rather than moving it to the Washington, D. C. area, was read for the information of the committee.

A statement of policy concerning relations between physicians and hospitals, as adopted by the Council of the Tennessee State Medical Association, was reviewed and by consent it was agreed that this matter should be referred to the Council.

Letter from the State Board of Health concerning obtaining a county health officer in Clay County was read and upon motion of Drs. Neumann and Wilkens the secretary was instructed to write the Clay County Medical Society, hoping the society would find someone in the society to serve in this capacity.

A letter from K. L. Kaufman soliciting financial support of the association of Science Fair International by assisting in paying the transportation costs of regional winners was reviewed and on motion of Drs. Wood and Wilkens this was referred to the Council.

The request of the Western Distributing Company for use of the association mailing list was refused.

Upon motion of Drs. Wilkens and Neumann, renewal of the association's membership in the United States Chamber of Commerce in the amount of $50.00 was approved.

The Student Loan note, application, and agreement form were reviewed and upon motion of Drs. Neumann and Wood, these forms were approved and the secretary was instructed to direct a letter to the councilors who had commented upon this subject and to point out to them the action of the Council at the January meeting.

A letter from the American Medical Association setting forth the policy statement adopted by the American Psychiatric Association was reviewed and upon motion of Dr. Wood, taken by consent, the secretary is to advise the American Psychiatric Association and the American Medical Association that in Indiana the communication between the

psychiatrist and his patient is already privileged.

The attorney discussed the recent action of the Internal Revenue Service in not approving some physician corporations in some of the other states.

A letter was read from the American Medical Association advising that the association would be contacted by representatives of the Indiana State Nurses Association for a discussion directed toward clarifying the dependent and independent function of the nurse.

The request of the Indiana League for Nursing asking the association to allow its name to be used as a co-sponsor of an Institute on Today's Child, to be held in Gary, Indiana, was approved on motion of Drs. Wood and Wilkens.

The secretary advised the committee that he had received a notice of a public hearing on a variance in zoning to permit the construction of a two story office building at 3909 North Meridian Street.

The committee was informed that the administrator of the State Department of Welfare had, at the request of the association, named John M. Paris, M.D., as a member of the advisory committee for implementation of Kerr-Mills in Indiana.

The recent actions taken by the Board of Trustees of the American Medical Association were reviewed and the secretary was instructed to duplicate these and send them to all of the officers of the association.

Future Meetings

April 10-11, 1964—Board of Directors, Indiana Chamber of Commerce, French Lick. No representative will be sent to this meeting.

April 16-18, 1964—AMA Legal Conference, Chicago. Upon motion of Drs. Wood and Wilkens, Mr. Bush is to represent the association at this meeting.

April 26-29, 1964—Plans were discussed for the annual meeting with the Indiana delegation in the Congress and letter was read from the Indiana State Chamber of Commerce concerning the Indiana Congressional Dinner in Washington, Tuesday, April 28. The secretary was instructed to procure tickets for all who attend from the State Medical Association.

May 1-2, 1964—AMA Congress on Environmental Health Problems, Chicago. Dr. Emmett Lamb, or someone from the Commission on Public Health, was authorized to attend this meeting, on motion of Dr. Neumann, taken by consent.

The schedule of district meetings was reviewed. It was suggested that Dr. Ramsey represent the association at the First District meeting, Dr. Black at the Second District, Dr. Wilkens at the Fourth District, Dr. Olvey at the Sixth District, Dr. Everly at the Seventh and Eighth, Dr. Wood at the Ninth.

The secretary was instructed to write the Third and Twelfth Districts, advising them that their district meeting dates conflict with Indiana University Alumni Day, at which Dr. Annis is to be the speaker.

AMA Annual Session, San Francisco, June 21-26, 1964. Plans for the San Francisco meeting of the AMA were discussed and Dr. Wilkens stated that Dr. Olvey would attend in his place, and upon motion of Drs. Neumann and Wilkens, Mr. Bush was authorized to attend.

There being no further business the meeting was adjourned, to meet again at 4:00 p.m., April 25, 1964, at the headquarters office. ◄

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By Gertrude Beard, R.N., R.P.T., Formerly Associate in Physical Medicine and Technical Director, Course in Physical Therapy, Northwestern University Medical School; and Elizabeth C. Wood, A.M., R.P.T., Associate Professor of Physical Medicine and Educational Administrator, Programs in Physical Therapy, Northwestern University Medical School. About 176 pages, 7¼" x 10¼". with about 250 illustrations. About $6.00. *New—Just Ready!*

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June 1964

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

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All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members. Cost of color illustrations must be shared by the author.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible. However, the right is reserved to reduce in length or reject any article.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication in THE JOURNAL of the Indiana State Medical Association.

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Advertising rates will be furnished on request. Copy must be received by the 5th of the month preceding month of issue. (Scientific manuscripts must be received at least two weeks earlier if geared for a specific issue.)

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The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Supervised by THE COUNCIL

Volume 57 — June 1964 — Number 6

Outpatient Mental Health Facilities In the State of Indiana: 1964

*BERNARD LUBIN, Ph.D.**
ALBERT LINCH, M.S.W.†
Indianapolis

THIS DIRECTORY is based upon information compiled from a mail survey conducted in March, 1964. Copies of the survey mailing list were sent to all agencies listed in the previous directory with the request that corrections should be noted on the questionnaire. By this method, information was collected from 31 psychiatric and psychological clinics, and 32 additional facilities which offer primarily psychological testing, special education services, counseling services or casework services. The directory can be considered complete through March 15, 1964.

Information about psychiatric clinics are presented by the city of location, in the following form:

> Name of facility. Address. Telephone number. Medical director and/or administrator. Area served. Age limits of clients served. Schedule of the facility. Number of full-time (FT) and part-time (PT) professional staff and trainees, and hours served. Services to clients. Application procedure. Fees for services.

One asterisk (*) denotes that the facility is partially supported by the Indiana Department of Mental Health; two asterisks (**) denote that the facility is entirely supported by the Indiana Department of Mental Health.

Additional facilities are listed according to city of location in two special sections.

Bloomington

Indiana University Psychological Clinic, Psychology Building. 332-0211.

> Delton C. Beier, Ph.D. Serves Monroe and surrounding counties. Age limit: none. Daily including Saturday morning. Psychiatrist, 1 FT, 40 hours; clinical psychologists, 9 PT, 130 hours, 33 trainees, 330 hours; psychiatric social workers, 1 FT, 40 hours. Services: diagnosis and psychotherapy. Application procedure: letter, phone call, and in-person interview with psychiatric social worker. Fees: intake interview—$3.00; treatment interview—$1.00; psychological testing—$10.00.

Columbus

*Bartholomew County Mental Health and

*Director, Division of Research and Training, Indiana Department of Mental Health and assistant professor, Department of Psychiatry, Indiana University Medical School.

†Director, Division of Community Mental Health Services, Indiana Department of Mental Health.

Guidance Center, 1541 Hutchins Ave. 372-7877.

George C. Weinland, M.D. Serves Bartholomew and Brown counties. Age limit: none. Daily including Saturday mornings. Psychiatrist, 1 FT, 40 hours; clinical psychologist, 2 FT, 80 hours, 1 PT, 8 hours; psychiatric social workers, 2 FT, 80 hours. Services: diagnosis, psychotherapy, counseling and guidance. Application procedure: must be physician referred. Fees: sliding scale.

Elkhart

*Adult and Child Guidance Clinic of Elkhart County, Inc., 224 West High St. JA. 2-4522.

John U. Keating, M.D. Serves Elkhart county. Age limit: none. Daily, including Monday evening, except Saturday. Psychiatrists, 1 FT, 38 hours; clinical psychologists, 2 PT, 20 hours; psychiatric social workers, 2 FT, 76 hours. Services: diagnosis, psychotherapy, counseling and guidance, consultations for other agencies. Application procedure: letter, phone, self-referral. Fees: sliding scale.

*Oaklawn Psychiatric Center, Inc., 2600 Oakland Ave. JA. 3-3350.

Otto D. Klassen, M.D., Medical Director; Robert W. Hartzler, Administrator. Serves primarily a 60-mile radius around Elkhart. Age limit: none. Daily except Saturday. Psychiatrists, 2 FT, 80 hours; clinical psychologists, 2 FT, 80 hours; psychiatric social workers, 4 FT, 160 hours; psychiatric nurses, 2 FT, 80 hours; occupational therapist, 1 FT, 40 hours; chaplain, 1 FT, 40 hours; aides, 2 FT, 80 hours. Services: diagnosis, psychotherapy, counseling and guidance, consultation, day hospital. Application procedure: letter, phone, self-referral. Fees: $25.00 per interview (e.g. intake, treatment, collateral and diagnostic); $25.00 psychological testing; $20 per day in day hospital.

Evansville

*Vanderburgh Child Guidance Center, 1 North Barker Ave. HA. 4-8227.

Lillian G. Moulton, M.D. Serves in 100-mile radius. Age limit: maximum—18 years. Daily except Saturday. Psychiatrist, 1 FT, 40 hours; clinical psychologist, 1 PT, 24 hours; psychiatric social workers, 3 FT, 120 hours, 2 trainees, 40 hours; speech therapist, 1 PT, 4 hours. Services: diagnosis, psychotherapy, counseling and guidance. Application procedure: parent or legal guardian completes application form and has medical form completed. Fees: sliding scale.

Fort Wayne

*Adult Psychiatric Center of North East Indiana, Inc., 227 E. Washington Blvd. 743-5471.

William C. Lyon, M.D. Serves Allen, Huntington, Wells, DeKalb, Adams and Noble counties. Age limit: minimum—17 years. Daily except Saturday. Psychiatrists, 3 PT; clinical psychologists, 1 FT, 37½ hours, 1 PT, 22½ hours; psychiatric social workers, 2 FT, 75 hours. Services: diagnosis, psychotherapy, counseling and guidance. Application procedure: must be physician referred. Fees: sliding scale.

*Fort Wayne Child Guidance Center, Inc., 227 E. Washington Blvd. 743-5471.

Robert L. Greenlee, M.D. Serves Allen county primarily (diagnostic services to adjoining counties.) Age limit: maximum 16 years. Daily except Saturday. Psychiatrists, 1 FT, 37½ hours; clinical psychologists, 3 FT, 112½ hours, 2 PT, 16 hours, 1 trainee, 8 hours; psychiatric social workers, 4 FT, 150 hours, 1 PT, 10 hours. Services: diagnosis, psychotherapy, counseling and guidance, consultation to other agencies, community mental health education. Application procedure: letter, phone call. Fees: sliding scale.

Gary

*Lake County Mental Health Clinic, 4801 W. Fifth Ave. 949-3222.

Krystyna Sklenarz, M.D., Medical Director; Mary E. Redfox, Administra-

tive Assistant. Serves Lake county. Age limit: none. Daily including evenings and Saturday until 1:00 p.m. Psychiatrists, 6 PT, 54 hours; clinical psychologists, 3 FT, 114 hours; psychiatric social workers, 6 FT, 228 hours, 1 PT, 19 hours. Services: diagnosis, psychotherapy, counseling and guidance, consultation programs to Bethany Children's Home and Lake County Children's Home, and special classes for emotionally disturbed children for the Gary public schools. Application procedure: letter, phone call, self-referrals, schools, courts, public clinics, health agencies, welfare agencies, physicians, lawyers, ministers, etc. A medical report is required on self-referrals. Fees: sliding scale.

**Northwest Indiana Alcoholism Clinic, 4938 W. Fifth Ave. 949-4275.

Anna S. Brand, M.D. Serves northwest Indiana. Age limit: adults only. Daily except Saturday. Psychiatric social workers, 2 FT, 80 hours; physician, 1 FT, 40 hours; alcoholism counselor, 1 FT, 40 hours; psychiatric nurses, 1 FT, 40 hours. Services: diagnosis, counseling and guidance. Application procedure: phone call for appointment. Fees: none.

Indianapolis

Adult Psychiatry Out-Patient Clinic, Indiana University Medical Center. ME. 5-8431.

John E. Kooiker, M.D. Serves all counties of Indiana. Age limit: minimum—16 years. Daily except Saturday. Psychiatrists, 1 FT, 40 hours, 2 PT, 40 hours, 2 trainees, 80 hours; clinical psychologists, 2 FT, 80 hours, 1 PT, 25 hours, 1 trainee, 40 hours; psychiatric social workers, 1 FT, 40 hours, 1 PT, 30 hours, 4 trainees, 80 hours. Services: diagnosis, psychotherapy, counseling and guidance, teaching. Application procedure: letter, phone call, physician. Fees: intake or diagnostic interview—$10.00; treatment interview—$5.00; psychological testing, $10.00—$25.00.

**Central Indiana Alcoholism Clinic, Bahr Treatment Building, 3000 W. Washington St. ME. 9-5304.

Jerome V. Pace, M.D. Serves Marion and surrounding counties. Age limit: adults only. Services provided to alcoholic patients and their families only. Daily, including Monday evening until 9:00 p.m., except Saturday. Psychiatrists, 1 PT, 2 hours; clinical psychologists, 1 PT, 6 hours; psychiatric social workers, 1 FT, 37½ hours, 2 PT, 30¾ hours. Services: diagnosis, counseling and guidance, pre-hospital evaluation and consultation. Application procedure: self-referral, letter, phone. Fees: none.

*Child Guidance Clinic of Marion County, Inc., 1949 E. 11th St. ME. 2-5381.

Edward C. Shipley, M.D. Serves Marion and Boone counties. Age limit: maximum—17 years. Daily except Saturday. Psychiatrists, 1 FT, 37½ hours, 1 PT, 18¾ hours; clinical psychologists, 2 FT, 75 hours, 1 PT, 18¾ hours, 1 trainee, 37½ hours; psychiatric social workers, 3 FT, 112½ hours, 1 PT, 30 hours, 3 trainees; psychiatric nurses, 1 PT, 15 hours. Services: diagnosis, psychotherapy, counseling and guidance, pre-school nursery program. Application procedure: social agencies, physician and self-referrals. Fees: sliding scale.

Episcopal Community Services, Inc., 1535-37 Central Ave. ME. 5-2538.

David L. Phillips, M.D., Medical Director; The Rev. Peter C. Moore, Executive Director. Serves Episcopal Diocese of Indianapolis and southern two-thirds of state. Age limit: minimum—eight years. Tuesday evening. Psychiatrists, 1 PT, 3 hours; clinical psychologists, 3 PT, 9 hours; psychiatric social workers, 1 FT, 43 hours, 2 PT, 6 hours. Services: diagnosis, psychotherapy, counseling and guidance. Application procedure: letter, phone, or through clergy of Episcopal Diocese. Fees: no information.

*James Whitcomb Riley Child Guidance

Clinic, Riley Hospital, Indiana University Medical Center, 1100 W. Michigan St. ME. 5-8431.

Edward A. Tyler, M.D. Serves state of Indiana. Age limit: maximum—16 years. Daily except Saturday. Psychiatrists, 1 FT, 40 hours, 1 PT, 30 hours, 3 trainees, 120 hours; clinical psychologists, 3 FT, 120 hours, 2 trainees, 48 hours; psychiatric social workers, 4 FT, 160 hours, 2 trainees, 48 hours; sociologists, 1 trainee, 8 hours; medical students, 3 trainees, 120 hours; chaplains, 3 trainees, 48 hours. Services: diagnosis, psychotherapy, counseling and guidance. Application procedure: must be physician referred. Fees: sliding scale.

**LaRue D. Carter Memorial Hospital—Outpatient Clinic, 1315 W. 10th St. ME. 4-8401.

Joseph A. FitzGerald, M.D. Serves entire state. Age limit: minimum—four years. Daily except Saturday. Psychiatrists, 2 PT, 30 hours, 10 trainees, 20 hours; clinical psychologists, 1 trainee, 8 hours; psychiatric social workers, 1 FT, 40 hours, 4 PT, 22 hours. Services: diagnosis, psychotherapy, counseling and guidance, consultation, training, public service, education. Application procedure: telephone call or letter to clinic to schedule screening interview. Fees: sliding scale. Evaluation, $4—$20; treatment, $1—$15.

Neurology Clinic, Marion County General Hospital, 960 Locke St. ME. 6-6331.

Wesley A. Kissel, M.D. (Information not available at the present time.)

Pediatric Neurology Clinic, Riley Hospital, 1100 W. Michigan St. ME. 5-8431.

Arthur L. Drew, M.D. Serves all counties. Age limit: maximum—18 years. Thursday morning and afternoon, and Friday morning. Neurologists, 3 PT, 36 hours, 3 trainees, 36 hours; clinical psychologists, 2 PT, 24 hours; social workers, 2 PT, 24 hours; psychometrician, 1 PT, 12 hours; occupational therapist, 1 PT, 12 hours; nurse, 1 PT, 12 hours. Services: diagnosis, counseling and guidance, treatment. Application procedure: physician, medical center clinics or public health nurses. Fees: psychological testing—$5.00; E.E.G.—$25.00; clinic visit—$5.00.

Psychiatry Clinic, Marion County General Hospital, 960 Locke St. ME. 6-6331.

Wesley A. Kissel, M.D. (Information not available at the present time.)

Veterans Administration Regional Office Mental Hygiene Clinic, 36 S. Pennsylvania St. ME. 3-7000.

John W. Crawford, M.D., Medical Director; Robert H. Fortier, Ph.D., Administrator. Serves state of Indiana except Lake, Porter, and LaPorte counties. Age limit: none. Services provided to veterans who are service connected for a neuro-psychiatric disability. Daily except Saturday. Psychiatrists, 2 PT, 12 hours; clinical psychologists, 2 FT, 80 hours, 1 PT, 8 hours, 8 trainees, 165 hours; psychiatric social workers, 2 FT, 80 hours. Services: diagnosis, psychotherapy, counseling and guidance. Application procedure: veteran may be self or other referred and must fill out application for treatment. Fees: none.

Jeffersonville

*Southeastern Indiana Rehabilitation Center Mental Health Consultation and Education Project, Route 3, Box 320E. BU. 3-7908.

Joseph B. Brill, M.D., Medical Director; Richard M. Rembold, ACSW, Executive Administrator. Serves Jackson, Clark, Floyd, Scott, Washington, Orange, Switzerland, Jefferson, Harrison, Jennings and Crawford counties. Age limit: none. Daily except Saturday. Psychiatrists, 1 FT, 35 hours; clinical psychologists, 1 FT, 40 hours, 1 trainee; psychiatric social workers, 1 FT, 40 hours, 1 trainee. Services: diagnosis, counseling and referral services. Application procedure: physician, minister, teachers, etc. Fees: sliding scale.

Kokomo

*Guidance Center of Howard County, Inc.,

308 W. Taylor St. GL. 2-5667.

John M. Hoyt, M.D., Medical Director; David M. Barnett, ACSW, Administrator. Serves Howard and Tipton counties. Age limit: none. Daily, including Monday and Tuesday evenings, and Saturday morning and afternoon. Psychiatrist, 1 PT, 30 hours; clinical psychologists, 2 FT, 88 hours; psychiatric social workers, 1 FT, 48 hours. Services: diagnosis, psychotherapy, counseling and guidance, community relations. Application procedure: must be physician referred. Fees: sliding scale.

Lafayette

Purdue Psychological Clinic, Education Building, Purdue University, West Lafayette. 92-2754.

John M. Hadley, Ph.D. Serves generally the northern part of the state. Age limit: none. Daily, including Saturday morning. Psychiatrists, 2 PT, 10 hours; clinical psychologists, 2 FT, 80 hours, 6 PT, 120 hours, 10 trainees, 200 hours. Services: diagnosis, psychotherapy, counseling and guidance. Application procedure: letter or phone call. Fees: sliding scale.

*Tippecanoe County Mental Health Center, Inc., 2900 N. River Road, West Lafayette. GI. 7-1191.

Joe M. Martin, M.D. Serves Tippecanoe, Montgomery, White, Carroll, Fountain and Warren counties. Age limit: none. Daily except Saturday. Psychiatrists, 1 PT, 24 hours; clinical psychologists, 2 FT, 80 hours; psychiatric social workers, 2 FT, 80 hours, 1 PT, 16 hours. Services: diagnosis, psychotherapy, counseling and guidance, consultation. Application procedure: letter, phone, self-referral or appropriate referral source. Fees: sliding scale.

Logansport

*Guidance Center, Inc., 400 Barnes Building. 6441.

Heracleo Matheu, M.D. Serves Cass and Clinton counties. Age limit: none. Monday through Thursday, evenings only; Friday afternoon and evening; Saturday morning and afternoon. Psychiatrists, 1 PT; clinical psychologists, 1 PT; psychiatric social workers, 2 PT. (Information on hours scheduled not available). Services: diagnosis, psychotherapy, counseling and guidance. Application procedure: must be physician referred. Fees: sliding scale.

Marion

*Grant County Mental Health Clinic, 412 S. Boots St. NO. 4-5347.

Charman F. Palmer, M.D. Serves Grant county. Age limit: none. Daily, including Monday evenings, except Saturday. Psychiatrists, 1 PT, 20 hours; clinical psychologists, 1 FT, 40 hours, 1 PT, 2 hours; psychiatric social workers, 1 FT, 40 hours, 2 PT, 6 hours. Services: diagnosis, psychotherapy, counseling and guidance, consultation to community agencies. Application procedure: physician referral plus two clinic contacts. Fees: sliding scale.

Michigan City

*Adult and Child Guidance Clinic for LaPorte County, 701 Washington St. TR. 2-7279.

John M. Hoyt, M.D., Medical Director; James W. Lubs, ACSW, Administrator. Serves LaPorte county. Age limit: none. Daily, except Saturday, including Monday through Thursday evenings. Psychiatrists, 1 PT, 30 hours; clinical psychologists, 1 FT, 40 hours, 1 PT, 10 hours; psychiatric social workers, 1 FT, 40 hours, 2 PT, 18 hours, 1 trainee, 6 hours. Services: diagnosis, psychotherapy, counseling and guidance, consultation to other agencies. Application procedure: letter, phone, physician, self-referrals. Fees: courts —$25.00; schools—$25.00; individuals —sliding scale.

Richmond

*Child Guidance Clinic of Wayne County, Inc., 54 S. 15th St. 2-6139.

Robert W. Schmitt, M.D., Medical Director; Fred Fragner, ACSW, Administrative Director. Serves Wayne county. Age limit: children or children

and their parents. Daily, including Thursday evening, and Saturday morning. Psychiatrist, 1 PT, 20 hours; clinical psychologist, 1 FT, 40 hours; psychiatric social workers, 2 FT, 80 hours. Services: diagnosis, psychotherapy, counseling and guidance. Application procedure: letter, phone call. Fees: sliding scale.

South Bend

*St. Joseph County Adult and Child Guidance Clinic, 527 W. Colfax Ave. 233-5123.

A. H. Urruti, M.D. Serves St. Joseph county. Age limit: none. Daily, (except Wednesday afternoon), including Thursday evening and Saturday morning. Psychiatrists, 1 FT, 40 hours, 1 PT, 12 hours; clinical psychologists, 3 FT, 120 hours, 1 PT, 20 hours; psychiatric social workers, 3 FT, 118 hours. Services: diagnosis, psychotherapy, counseling and guidance, consultation with other agencies and in-service training. Application procedure: letter, phone. Fees: sliding scale.

Terre Haute

*Vigo County Adult and Child Guidance Center, 415 N. Ninth St. LI. 6291.

Harold E. Wilson, ACSW, Acting Administrator. Serves Vigo, Clay, Parke, Vermillion, and Sullivan counties. Age limit: none. Daily, including Saturday. Psychiatrists, 4 PT, 14½ hours; clinical psychologists, 1 FT, 48 hours; psychiatric social workers, 2 FT, 96 hours. Services: diagnosis, psychotherapy, counseling and guidance, consultation, teaching. Application procedure: letter or phone call. Fees: sliding scale.

Valparaiso

Porter County Guidance Clinic, Inc., 306½ Washington St. HO. 2-1909.

Myron E. Berkson, M.D. Serves Porter county. Age limit: none. Monday through Thursday afternoons, Saturday morning and afternoon. Psychiatrists, 1 PT, 10 hours; clinical psychologists, 1 PT, 10 hours, 1 trainee, 4 hours; psychiatric social workers, 1 PT, 20 hours, 1 trainee, 8 hours. Services: diagnosis, psychotherapy, counseling and guidance. Application procedure: letter or phone call. Fees: sliding scale.

Warsaw

*Four County Mental Health Clinic, Inc., 315 W. Center St. 267-7074.

Frank D. Hogle, M.D., Medical Director; Raymond J. Clausman, Ph.D., Administrator. Serves Kosciusko, Marshall, Wabash and Whitley counties. Age limit: none. Daily except Saturday. Psychiatrists, 1 PT, 20 hours; clinical psychologists, 1 FT, 40 hours; psychiatric social workers, 2 FT, 80 hours. Services: diagnosis, psychotherapy, counseling and guidance. Application procedure: letter, phone calls, self-referrals. Fees: sliding scale.

Additional Facilities in the State of Indiana

I. *Psychological testing, special education services, and counseling services.*

Evansville

Special Educational Services, Evansville College. GR. 6-1341.

Robert L. Wilson

Indianapolis

Bureau of Clinical Services, Butler University. WA. 3-3451.

Roger W. Coulson, Ph.D.
David P. Torbet, Ph.D.

Veterans Administration, Counseling Section for VR&E Division, 36 S. Pennsylvania St. ME. 3-7000.

Noble C. Lehner

Terre Haute

Special Education Clinic, Indiana State College. CR. 0231.

Rutherford Porter, Ph.D.

II. *Casework services, Counseling services.*

Anderson

Anderson Pastoral Care & Counseling Center, First Methodist Church, 12th and Jackson Sts. 643-6977.

Rev. Robert W. Fribley,
Director

Family Service of Madison County, 538 Citizens Bank Building. 642-5114.

Donald F. Maxstadt, ACSW,
Administrator

East Chicago

Catholic Family Service of East Chicago, 720 W. Chicago Ave. EX. 7-5803.
Rev. Joseph Semancik, Director

Elkhart

Family Counseling Service of Elkhart Co., 329 W. Franklin St. JA. 3-4402.
Eugene Talsma, ACSW,
Administrator

Evansville

Catholic Charities Diocese of Evansville, 602 Court Building. HA. 3-5456.
Rev. Chas. T. Schoettelkotte,
Director

Evansville Pastoral Care & Counseling Center, Central Methodist Church, Franklin & Mary Sts. HA. 4-3574.
Rev. W. W. Matzigkeit,
Director

Family & Children's Service, Inc. 313 S. E. Second St. HA. 5-5181.
Edward F. Ebert, ACSW,
Executive Director

Fort Wayne

Catholic Social Service, 919 Fairfield Ave. 743-7311.
Very Rev. Msg. John H. Reed,
Director

Family and Children's Service of Fort Wayne, Inc., 2424 Fairfield Ave. 744-4326.
Margaret Winchell, ACSW,
Executive Director

Fort Wayne Pastoral Care & Counseling Center, First Methodist Church, 326 E. Wayne St. 743-2684.
Rev. Bryant J. Howard, Director

Gary

Calumet Pastoral Care & Counseling Center, City Methodist Church, 575 Washington St. 885-8452.
Rev. Ronald S. Carlson, Director

Catholic Charities Diocese of Gary, 673 Broadway, Rm. 208. 887-6548.
Rev. Joseph Semancik, Director

Hammond

Catholic Family Services of Hammond, 5252 Hohman. WE. 3-0696.
Rev. Joseph Semancik, Director

Indianapolis

Catholic Charities Bureau, 623 E. North St. ME. 8-1371.
Rev. Donald Schmidlin, Director

Children's Bureau, 615 N. Alabama St., Room 312. ME. 4-6481.
James Mallon, ACSW,
Executive Director

Family Service Association of Indianapolis, 615 N. Alabama St., Rm. 210. ME. 4-6341.
Henry M. Graham, ACSW,
Executive Director

Indiana Area Methodist Pastoral Care & Counseling Center, 312 Chamber of Commerce Building. ME. 5-1183.
Rev. James E. Doty, Ph.D.,
Director

Indianapolis Pastoral Care & Counseling Center, North Methodist Church, 3808 N. Meridian St. WA. 4-2613.
Kenneth E. Reed, Ph.D.,
Administrator

Jewish Social Services, 615 N. Alabama St., Rm. 319. ME. 4-7401.
Mrs. Juanity K. Graham, ACSW,
Acting Director

Jeffersonville

New Albany Pastoral Care & Counseling Center, Wall Street Methodist Church, Wall & Chestnut Sts. BU. 2-9863.
Rev. Alda I. Carter, Director

Lafayette

Catholic Charities, 610 Lingle Ave., SH. 2-0275.
Rev. Louis Heitz, Director

Mishawaka

Family & Children's Center, Inc., 1411 Lincoln Way W. 255-3115.
Robert E. Pollitt, ACSW,
Executive Director

Muncie

Family Counseling Service, Inc., 615 E. Washington St. 284-7789.
Richard E. Huyck, ACSW,
Executive Director

Muncie Pastoral Care & Counseling Center, High Street Methodist Church, High & Adams Sts. 284-9946.
Rev. Harold D. Neel, Director

Richmond

Family Service Association of Wayne County, Inc., 10½ N. Tenth St. 2-3430.
June B. Harris, ACSW,
Executive Director

South Bend

Catholic Social Service, 207 S. Taylor St. AT. 9-5506.
Very Rev. Msg. John H. Reed,
Director

South Bend Pastoral Care & Counseling Center, First Methodist Church, 325 N. Main St. CE. 3-9463.
Rev. Keith Carlile, Director

Terre Haute

Family Service Association in Terre Haute, 912 Chestnut St. CR. 7381.
Keith Cook, ACSW,
Executive Secretary ◄

To Smoke or Not to Smoke

A recent report by the Royal College of Physicians of Great Britain has again attracted a good deal of attention to the problem of cigarette smoking. Although there is little new in the report, the English doctors do conclude that, while there are no known benefits from smoking, much harm can result. The authors of the impressive publication are careful to note that cigarette smoking probably increases the risk of dying from coronary heart disease in early middle life, but we must emphasize the word "probably." Obviously, some relationship exists between cigarette smoking and the increase of primary cancer of the lung, but just what that association is remains unknown.

It is interesting to note that heavy smoking is often associated with heavy drinking, and perhaps the drinking may be responsible for some of the evils attributed to cigarette smoking. At any rate little good comes from either—except perhaps for the psychologic or emotional reward, which certainly should not be considered lightly. Indeed, in many persons such rewards may offset some of the dangers inherent in these habits.

Since we pride ourselves highly in the freedom of the individual, let us not attempt to legislate against smoking—or drinking—in the hope of eliminating "evil." The drinking legislation was attempted once; no comments are necessary. Let us rather instruct the individual as to the potential dangers and then let each person decide for himself. We can't live forever, and if smoking and drinking—hopefully tempered with moderation—add to our pleasure, so be it!—John F. Briggs, M.D., in *Geriatrics*. Reprinted from *The West Virginia Medical Journal*, Vol. 59, No. 1, 1963.

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

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A Sense of Purpose*

MARK O. HATFIELD
Governor of Oregon

ONE OF THE mainsprings of economic progress is to be found in research and development. It is no secret that our strongest firms are deeply committed to the constant quest for new and better products. In Oregon, despite her distance from major markets, national and international markets have been created and held through the creative efforts of those who have guided the growth of research-oriented industry.

One hundred seventy-four years ago today (April 10, 1790) the national government first enacted a statute providing for the protection of patentable ideas. Until recently, it had been my understanding that it was still federal policy to encourage discovery and invention.

I have found, however, that our national government is not at all consistent and that we are now in an era of industrial piracy, seemingly fostered and abetted by the federal government.

In 1963, United States business spent $18.5 billion on research. Why? Obviously, because there are economic incentives for doing so.

The drug industry spends a significant share of the total. Along the way it has achieved protection against polio, pneumonia, diphtheria, and influenza. In the recent past, however, one of the nation's leading pharmaceutical firms found its formulas and processes for broad-spectrum antibiotics had been stolen and sold to Italian drug firms, and the U. S. Government was making many of its purchases from these foreign firms.

While it may be laudable for a government to seek the low bidder in securing its supplies, certainly there is a prior obligation to preserve and strengthen the protections afforded to those who are engaged in pushing our productive capacity forward. Take, for example, a West Coast firm, Electro-Scientific Industries. At considerable investment, it developed a new type of measuring instrument. The national gov-

*Excerpted from a speech given before the Chicago Executives Club, April 10, 1964.

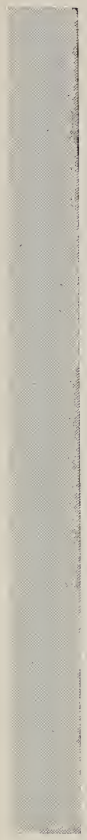
ernment bought one, turned it over to another firm to copy, and has since bought $5 million worth—from the firm that specialized in copying.

An employers' organization in Oregon recently endorsed a small beginning. It urged adoption of HR 1707, introduced by Congressman Richard L. Roudebush (Republican, Indiana). This bill would prohibit federal purchase of items of foreign manufacturers using illegally obtained American patents in producing their products. I certainly join in this endorsement.

There is more to be done, of course, but this is at least a beginning.

The protection of patents is important but more significant is the fact that, after 174 years, it should be ill-considered federal policies that create inadequacy in the protection they receive. ◄

About Our Cover



The dawn of medicine broke in ancient Greece, that rocky peninsula washed by sapphire seas, the country of Aesculapius and Hippocrates.

Aesculapius, according to mythology, was the son of the god Apollo and the nymph Coronis; he was hidden on a mountain by a centaur, Chiron, after his mother's dalliance with a mortal so enraged Apollo that he slew her. It was Chiron, half horse-half-man, who taught Aesculapius the arts of healing.

The cult of divine, magic-religious medicine that evolved with Aesculapius drew great numbers to his shrine. Temples for the worship of this god-healer were built throughout the Aegean Islands. Here the afflicted would come and, after elaborate ritual, would enter the temples and sleep. While sleeping, they would dream that Aesculapius with his staff and serpent, accompanied by his daughters, Hygeia and Panacea, passed among them and healed. To this day, Aesculapius' staff entwined with a single serpent is the symbol of medicine.

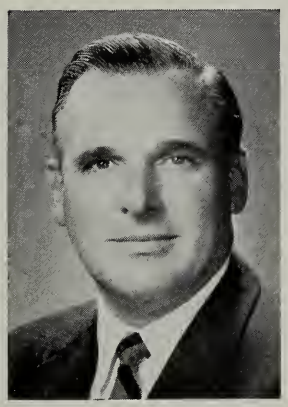
In 460 B.C., on the Island of Cos, Hippocrates was born, the man who might be called the Father of Medicine. Here was a man who practiced empiric medicine. He accepted the existence of many diseases rather than one. He believed in the curative powers of nature, recognized the therapeutic values of herbs, diet, sea baths and massage. Hippocrates was a teacher and writer as well as practicing physician. Seventy-two texts and 42 clinical histories are credited to him. These texts greatly enlarged man's knowledge of medicine and added to medical terminology such words as paroxysm, chronic, convalescence and relapse.

The greatest gift left by Hippocrates is the Hippocratic Oath, the oath sworn by all physicians; based on the rule that to be a good physician one must first be a good and kind man.

The photograph of the busts of Aesculapius and Hippocrates was taken in the lobby of the ISMA Headquarters by Philip T. Holland, M.D., of Bloomington. —M.E.R.

President's Page

During the past six weeks, Mrs. Wood and I have been traveling extensively on behalf of medicine. Our first trip was to Atlanta for a political workshop of 12 southern states. The workshop was attended by the presidents of the state societies along with the Political Action Committee president and auxiliary members. It was most beneficial and productive of new ideas and promises to lead to closer cooperation.



One week later we attended a similar workshop in New York City of 12 northeastern states. It was a successful program. Differences of opinion and viewpoints were rather marked and at times discussion somewhat heated. The end result of such meetings is always for better medical care and preservation of the private practice of medicine.

Our next trip was to Washington, D. C. for our annual meeting with our congressional delegation and their staffs. A highlight was the presentation of the AMA award to Lieutenant Elmer C. Paul, former member of the Indiana State Police, as the "originator of auto crash injury research." The dinner was attended by several members of the Health, Education and Welfare Department as well. Lt. Paul is now chief of the Protecting Device Section, Traffic Safety Branch, Division of Accident Prevention of H.E.W. Dr. and Mrs. Luther Terry were also in attendance. Senator Hartke was unable to attend because of family commitments. All-in-all our congressional delegation is hard working and deserves great credit.

Following this meeting, we attended the Ohio State Medical Association meeting in Columbus. This was very nice. Their problems and discussions are similar to ours in Indiana, but I did come away with some new ideas to present to our Council.

The next trip was to Madison, Wisconsin, for the Wisconsin State Meeting. They have many awards of civic interest as well as medical interest. Their banquet was an outstanding event.

We have also attended many local meetings of state importance. The annual "kick-off" meeting of the Indiana Association for Mental Health was a successful event. I am hopeful of the profession's continued support and cooperation in this field.

The primary is over, but our work still must continue. Join I-HOPE and AMPAC and help in any way you can.

Donald E. Wood

The Woman's Auxiliary

REPORTS TO ISMA

Our 20th annual House of Delegates met in Terre Haute, April 22-23, 1964. This meeting was truly wonderful, and I am convinced that many doctors' wives do not realize what they are missing by not attending our annual House of Delegates.



Your wife is most welcome at any of our area, state, and national meetings. If she attends she will find our programs most interesting and will return home with happy memories of pleasant experiences, new acquaintances and lasting friendships.

Please notice the events listed below and interest your wife in them. So much effort goes into preparation for these meetings that she is certain to find them well worth her time.

Now, more than ever before, it is important that doctors' wives meet together to discuss vital, current issues, and that we work together for a better America and a better world.

AUXILIARY EVENTS AND DATES

AMA Convention, San Francisco, Cal., June 21-25, 1964, St. Francis Hotel
ISMA Convention, Indianapolis, Ind., Oct. 14, 1964, Columbia Club
(Women's morning board meeting and luncheon)

AREA MEETINGS, 1964

NORTHERN—September 15 (Tuesday), Honeywell Memorial Bldg., Wabash, Ind.
CENTRAL—September 16 (Wednesday), ISMA Bldg., Indianapolis, Ind.
SOUTHERN—September 17 (Thursday), French Lick Sheraton Hotel, French Lick, Ind.

1964-1965 HOUSE OF DELEGATES

House of Delegates, Marott Hotel, Indianapolis, Ind., April 28-29, 1965

Bea Shields

ROSTER OF MEMBERS



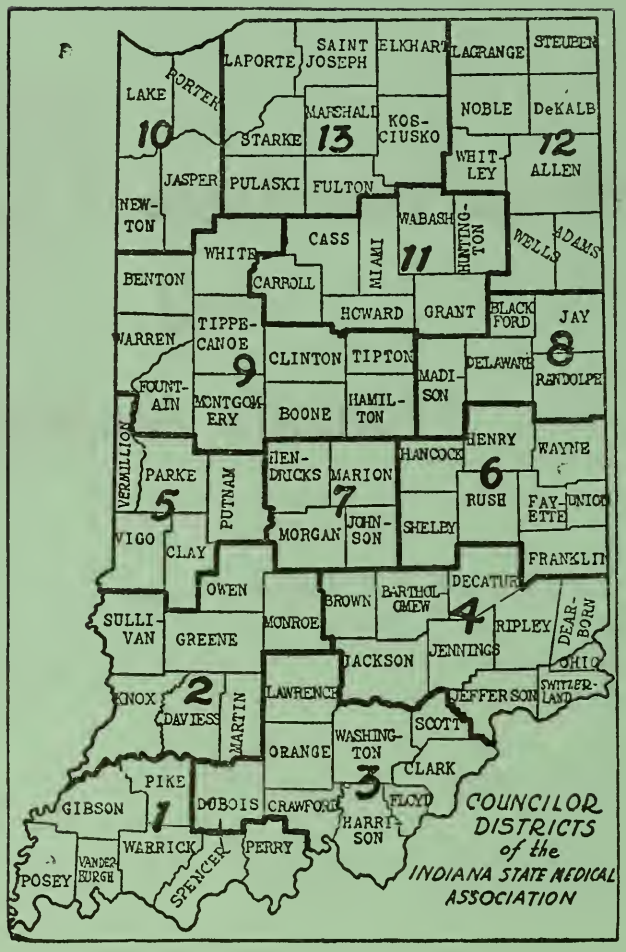
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Woman's Auxiliary

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CLARK
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GIBSON
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CRAWFORD
FLOYD
HARRI-SON
WARRICK
PERRY
VANDER-BURGH
POSEY
SPENCER
COUNCILOR DISTRICTS of the INDIANA STATE MEDICAL ASSOCIATION

Membership Roster

INDIANA STATE MEDICAL ASSOCIATION

Following is a list of paid-up members of the Indiana State Medical Association as of May 1, 1964.

The letter (S) following a name indicates that the physician is a senior member of his local society and of the Indiana State Medical Association. The letter (H) following a name indicates that the physician is an honorary member of his local society and the Indiana State Medical Association.

Physicians are listed in the county medical society in which they hold membership.

Names of members who have died during the year do not appear in this list.

If any errors are found in this list, please report them to THE JOURNAL, 3935 N. Meridian, Indianapolis 8, Indiana. The cooperation of members is urgently requested.

ALPHABETICAL LIST OF MEMBERS

For street addresses, see roster of members by counties, p. 571.

Name	City	County
	A	
Aagesen, Walter J.	Anderson	Madison
Abell, Charles F.	Marion	Grant
Abell, Charles F., Jr.	Marion	Grant
Able, Walter	Columbus	Bartholomew-Brown
Abramson, Allan L.	Gary	Lake
Acher, Robert P.	Greensburg	Decatur
Acker, Robert B. (S)	South Bend	St. Joseph
Acre, Robert R.	Evansville	Vanderburgh
Adair, Samuel L.	Jeffersonville	Clark
Adair, William K. (S)	Crothersville	Jackson-Jennings
Adams, Daniel S. (S)	Ft. Myers, Fla.	Marion
Adams, Julia L.	Muncie	Delaware-Blackford
Adams, E. Wade	Fort Wayne	Allen
Adams, Max R.	Flora	Carroll
Adams, William B.	Muncie	Delaware-Blackford
Adamski, Michael S.	Logansport	Cass
Addleman, Robert H.	Indianapolis	Marion
Ade, Charles H.	Lafayette	Tippecanoe
Ade, Mary Keller	Lafayette	Tippecanoe
Adkins, Harold C.	Indianapolis	Marion
Adler, David L.	Columbus	Bartholomew-Brown
Adler, Raymond N.	Evansville	Vanderburgh
Adney, Frank B.	Richmond	Wayne-Union
Adye, Wallace M.	Evansville	Vanderburgh
Agana, Adriano A.	Gary	Lake
Ahlbrand, Roland C.	Fort Wayne	Allen
Aiken, Arthur F.	Fort Wayne	Allen
Aiken, Milo M.	Plainfield	Hendricks
Aiken, Nevin E.	Fort Wayne	Allen
Ake, Loren	Richmond	Wayne-Union
Akre, Philip R.	La Jolla, Calif.	Marion
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Aldred, Allen W.	Indianapolis	Marion
Aldrich, Harry D.	Indianapolis	Marion
Aldrich, Howard	Indianapolis	Marion
Alexander, Ezra D.	Indianapolis	Marion
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Alfano, Joseph E.	Hammond	Lake
Alfano, Paul A.	Gary	Lake
Alig, Vincent B.	Indianapolis	Marion
All, Barbara B.	Indianapolis	Marion
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Altier, William H.	Fowler	Benton
Alvarez, Paul	Gary	Lake
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Ambrozaitis, Kazys	Gary	Lake
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Anderson, James W.	Indianapolis	Marion
Anderson, John B.	Vincennes	Knox
Anderson, John T.	Zionsville	Marion
Anderson, Milton H.	Evansville	Vanderburgh
Anderson, Richard M.	Vincennes	Knox
Anderson, Robert C.	Richmond	Wayne-Union
Anderson, Walter C.	Terre Haute	Vigo
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Andrews, Fred B.	Columbus	Bartholomew-Brown
Andrews, Hugh K.	Franklin	Johnson
Angel, Virgil E.	Highland	Lake
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Ansbacher, Stefan (H)	Marion	Grant
Anshutz, William M.	Indianapolis	Marion
Antes, Earl H.	Evansville	Vanderburgh
Antreasian, Berj	Indianapolis	Marion
Appel, Richard H.	Indianapolis	Marion
Apple, Eddie R.	Salem	Washington
Applegate, Albert E.	Frankfort	Clinton
Arata, James A.	Fort Wayne	Allen
Arata, Justin E.	Fort Wayne	Allen

Name	City	County
Arata, Lucian A.	Shelbyville	Shelby
Arbeiter, Herbert I.	Munster	Lake
Arbogast, John L.	Indianapolis	Marion
Arbogast, Paul B.	Vincennes	Knox
Arbuckle, William E. (S)	Indianapolis	Marion
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Arney, Amos	Michigan City	La Porte
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Arnold, Robert D.	Indianapolis	Marion
Aronson, Sidney S.	Indianapolis	Marion
Arrowsmith, James L.	Munster	Lake
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Austin, Charles E.	Anderson	Madison
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Austin, Maynard A. (S)	Evansville	Madison
Austin, Richard P.	Bedford	Lawrence
Avery, George O.	Indianapolis	Marion
Ayres, Wendell W.	Marion	Grant

B

Babb, Forrest J.	Stockwell	Tippecanoe
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Baum, John R.	Warsaw	Kosciusko
Baumeister, Herbert E.	Indianapolis	Marion
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Baxter, John P.	Indianapolis	Marion
Baxter, Neal E.	Bloomington	Owen-Monroe
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Beamer, Parker R.	Indianapolis	Marion
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Bean, Joseph S.	Logansport	Cass
Beardsley, Frank A., Jr.	Frankfort	Clinton
Beaven, John B.	Jasper	Dubois
Beaver, Ernest R.	Rensselaer	Jasper
Beaver, Howard W.	Indianapolis	Marion
Beaver, Norman E.	Berne	Adams

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Bebensee, Donald L.	South Bend	St. Joseph
Bebout, Donald E.	Evansville	Vanderburgh
Bechtold, Samuel E.	South Bend	St. Joseph
Beck, David C.	Monticello	White
Beck, Evart M.	Indianapolis	Marion
Beck, Robert E.	Evansville	Vanderburgh
Beck, Thomas A.	Swayzee	Grant
Becker, Harry G.	Indianapolis	Marion
Becker, Philip H.	Crown Point	Lake
Becker, Samuel W.	Whiting	Lake
Beckes, Ellsworth W.	Vincennes	Knox
Beconovich, Robert	Hammond	Lake
Bedwell, Marion H.	Sullivan	Sullivan
Beebe, Milton O., Jr.	Rockville	Parke-Vermillion
Beeler, Franklin K.	Anderson	Madison
Beeler, John W.	Indianapolis	Marion
Beeler, Raymond C. (S)	Indianapolis	Marion
Beer, Alan E.	Tuba City, Ariz.	Marion
Beeson, Wilbur P.	Greenfield	Hancock
Begley, Joseph W., Jr.	Evansville	Vanderburgh
Beggs, Lowell F.	Columbus	Bartholomew-Brown
Behn, Walter M.	Gary	Lake
Beierlein, Karl M.	Fort Wayne	Allen
Beights, Raymond S.	Fort Wayne	Allen
Beisel, Larry H.	Evansville	Vanderburgh
Belding, Ray T.	Kokomo	Howard
Bell, Horace D.	South Bend	St. Joseph
Bell, Robert L.	South Bend	St. Joseph
Belshaw, George	Indianapolis	Marion
Belt, James H.	Indianapolis	Marion
Benages, Anthony G.	Jasper	Dubois
Benchik, Frank A.	East Chicago	Lake
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Bender, Robert L.	Elkhart	Elkhart
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Benedict, Charles D.	LaGrange	LaGrange
Benedict, Paul F.	Indianapolis	Marion
Benham, Lawrence E.	Bedford	Lawrence
Benken, Lawrence D.	Muncie	Delaware-Blackford
Bennett, Abner P.	Evansville	Vanderburgh
Bennett, Ivan F.	Indianapolis	Marion
Bennett, J. B.	Warren	Huntington
Bennett, Jene R.	South Bend	St. Joseph
Benson, James E.	Elkhart	Elkhart
Benz, Jesse C. (S)	Marengo	Harrison-Crawford
Benz, Owen F.	Wanatah	La Porte
Bergal, Milton B.	Gary	Lake
Bergan, Joseph A.	Michigan City	La Porte
Bergendahl, Emil H.	Fort Wayne	Allen
Berger, Morley	Beech Grove	Marion
Berghoff, James R.	Fort Wayne	Allen
Bergwall, Warren L.	Muncie	Delaware-Blackford
Berke, Robert D.	South Bend	St. Joseph
Berkshire, Shaffer B.	North Vernon	Jackson-Jennings
Berkson, Myron E.	Michigan City	La Porte
Berman, Edward J.	Indianapolis	Marion
Berman, Jacob K.	Indianapolis	Marion
Bernard, Marvin R.	Gary	Lake
Berner, Herbert W., Jr.	Indianapolis	Marion
Bernoske, Daniel G.	Gary	Lake
Berry, John M.	Indianapolis	Marion
Best, Robert C.	Whiting	Lake
Bethea, Dennis A. (S)	Hammond	Lake
Bethea, Robert O.	Farmersburg	Sullivan
Beuerman, V. A.	Lafayette	Tippecanoe
Beutler, Theodore V.	Fort Wayne	Allen
Beverland, Malon E. (S)	Indianapolis	Marion
Biasini, Benedict A.	South Bend	St. Joseph
Bibler, Henry E.	Muncie	Delaware-Blackford
Bibler, Lester D.	Indianapolis	Marion
Bickel, David A. (S)	South Bend	St. Joseph
Bickers, Everett E.	New Albany	Floyd
Bidney, Evelyn B.	Bloomington	Owen-Monroe
Bigler, Frederick W.	Goshen	Elkhart
Bill, Robert O.	Indianapolis	Marion
Billings, Elmer R.	Elkhart	Elkhart
Billingsley, John S.	Fort Wayne	Allen
Bills, R. James	Gary	Lake
Bills, Robert N.	Gary	Lake
Birdzell, John P.	Crown Point	Lake
Birmingham, Peter J. (S)	South Bend	St. Joseph
Birum, Patricia J.	Union City	Randolph
Bishop, Harry A.	Frankton	Madison
Bissonnette, Roger P.	Evansville	Vanderburgh
Bixler, Donald P.	Anderson	Madison
Bixler, Louis C.	South Bend	St. Joseph
Bizer, Mier A.	Jeffersonville	Clark
Black, Boyd K.	Vincennes	Knox
Black, Henry R.	Indianapolis	Marion
Black, M. James	Brownsburg	Hendricks
Black, Joe M.	Seymour	Jackson-Jennings
Blackburn, Erwin	Westville	St. Joseph
Blackburn, Howard R.	Noblesville	Hamilton
Blackford, Florence	Indianapolis	Marion
Blackford, Ralph E. (S)	Indianapolis	Marion
Blackwell, Donald S.	Indianapolis	Marion
Blaisdell, Glenn D.	Kokomo	Howard
Blake, Albert L.	Indianapolis	Marion
Bland, Jack D.	Holland	Dubois
Blassaras, Crist A.	Anderson	Madison
Blatt, A. Ebner	Indianapolis	Marion
Blazey, Arthur G.	Washington	Daviess-Martin
Bledsoe, James G.	New Castle	Henry
Blessinger, Louis H.	Corydon	Harrison-Crawford
Blichert, Peter A.	Fort Wayne	Allen
Blix, Fred M.	Ladoga	Montgomery
Bloemker, Edward F.	Indianapolis	Marion
Bloom, Asa W.	Marion	Grant
Bloom, George R.	Elkhart	Elkhart
Bloomer, Richard S.	Rockville	Parke-Vermillion
Bloss, Bryant A.	Evansville	Vanderburgh
Blosser, Blaine A. (S)	Fremont	Steuben
Blossom, Paul W.	Richmond	Wayne-Union
Blum, Leon L.	Terre Haute	Vigo
Boaz, William D.	Wabash	Wabash
Bobb, Kenneth E.	Seymour	Jackson-Jennings
Bodnar, Leslie M.	South Bend	St. Joseph
Bogan, William C.	South Bend	St. Joseph
Bogardus, Carl R.	Austin	Scott
Boggs, Eugene F.	Indianapolis	Marion
Bohner, Caryle B.	Hidalgo, Mexico	Marion
Bolin, Robert C.	Lafayette	Tippecanoe
Boling, Frederick F.	Indianapolis	Marion
Boling, Grover C.	Indianapolis	Marion
Boling, Richard C.	Elkhart	Elkhart
Bolman, Ralph M.	Fort Wayne	Allen
Bomalaski, M. Donald	Indianapolis	Marion
Bomba, Brad J.	Bloomington	Owen-Monroe
Bombar, Leslie E.	Munster	Lake
Bonaventura, Angelo P.	Highland	Lake
Bond, George S. (S)	Indianapolis	Marion
Bond, Virginia	Indianapolis	Marion
Bond, Walter C.	Clay City	Clay
Bond, William H.	Indianapolis	Marion
Bone, James A.	Westville	La Porte
Bonsett, Charles A.	Indianapolis	Marion
Booher, Norman R.	Indianapolis	Marion
Booher, Olga Bonke	Indianapolis	Marion
Booker, Harold E.	Indianapolis	Marion

Name	City	County
Boone, Robert D.	Evansville	Vanderburgh
Boonstra, Charles E.	Bluffton	Wells
Booth, Boynton H.	Indianapolis	Marion
Booth, Franklin M.	South Bend	St. Joseph
Booze, James H.	Bloomington	Owen-Monroe
Bopp, Henry W., Jr.	Terre Haute	Vigo
Bopp, James	Terre Haute	Vigo
Borak, Walter J.	Gary	Lake
Borden, Tom P.	Kincheloe AFB, Mich.	Marion
Boren, Paul R.	Poseyville	Posey
Bornstein, Herschel	Gary	Lake
Borland, Raymond M.	Bloomington	Owen-Monroe
Borough, Lester D.	South Bend	St. Joseph
Bosch, Ralph	Seymour	Jackson-Jennings
Bosler, Howard A.	Goshen	Elkhart
Bossard, John W.	Fort Wayne	Allen
Boswell, Robert W. C.	Evansville	Vanderburgh
Botkin, Charles L. (S)	Muncie	Delaware-Blackford
Botkin, Charles T.	Muncie	Delaware-Blackford
Botkin, Clyde G.	Muncie	Delaware-Blackford
Boughman, Joe D.	Kokomo	Howard
Bowdoin, George E. (S)	Elkhart	Elkhart
Bowen, Gerald T.	Lawrenceburg	Dearborn-Ohio
Bowen, Otis R.	Bremen	Marshall
Bowers, Charles R.	Anderson	Madison
Bowers, Copeland C.	Kokomo	Howard
Bowers, Gah T.	Fort Wayne	Allen
Bowers, Garvey B.	Kokomo	Howard
Bowers, George W.	Fort Wayne	Allen
Bowers, John A.	Indianapolis	Marion
Bowers, John A.	Kokomo	Howard
Bowers, Jesse W. (S)	Fort Wayne	Allen
Bowman, Charles M.	Albion	Noble
Bowman, Geo. W. (S)	Indianapolis	Marion
Bowser, Philip G.	Goshen	Elkhart
Boyd, Charles S.	East Chicago	Lake
Boyd, H. Clark	Terre Haute	Vigo
Boyd, Stella N.	Evansville	Vanderburgh
Boyer, Don W.	Lebanon	Boone
Boyer, Floyd A.	Indianapolis	Marion
Boyer, Grace B.	Marion	Grant
Boys, Frank F.	East Chicago	Lake
Boze, Robert L.	Berne	Adams
Bradley, Louis F.	Bluffton	Wells
Bradley, Richard V.	Kokomo	Howard
Bradley, Stephen C. (S)	Terre Haute	Vigo
Brady, Samuel G.	Gary	Lake
Brady, Thomas A.	Indianapolis	Marion
Brakel, Frank J., Jr.	Evansville	Vanderburgh
Branco, Arthur M.	Munster	Lake
Brand, Anna	Gary	Lake
Brandman, Harry	Gary	Lake
Brandt, William E.	Fort Wayne	Allen
Brauchla, Carl H. (S)	Anderson	Madison
Brauer, Abraham A.	Westville	Lake
Braun, Benjamin D.	East Chicago	Lake
Braunlin, Robert J.	Fort Wayne	Allen
Brayton, John R., Jr.	Castro Valley, Calif.	Marion
Brayton, John R., Sr.	Indianapolis	Marion
Brayton, Lee	Indianapolis	Marion
Brazelton, Osborne T. (S)	Seal Beach, Calif.	Gibson
Brechtl, Harvey J.	South Bend	St. Joseph
Breedlove, C. Dane	Fairmount	Grant
Breneman, William L.	Fort Worth, Texas	Marion
Brennan, William C.	Whiting	Lake
Brenner, Howard B.	Munster	Lake
Bretz, John M.	Huntingburg	Dubois
Brickley, Harry D.	Indianapolis	Marion
Brickley, Richard A.	Indianapolis	Marion
Bridge, Barton C.	Anderson	Madison
Bridges, Alvin L.	Lafayette	Tippecanoe
Bridges, William L.	Fort Wayne	Allen
Bridwell, Edgar	Bedford	Lawrence
Briggs, Robert W.	Indianapolis	Marion
Brill, Joseph B.	Jeffersonville	Clark
Brillhart, James R.	Indianapolis	Marion
Brincko, John	Gary	Lake
Brink, Calvin C. (S)	Gary	Lake
Bristol, Henry M. S.	Terre Haute	Vigo
Britt, Robert L.	Evansville	Vanderburgh
Britton, Welbon D.	Montezuma	Parke-Vermillion
Brock, Earl E. (S)	Anderson	Madison
Brock, Joseph T.	New Castle	Henry
Brockman, Wilfred J.	Corydon	Harrison-Crawford
Brockmole, Arnold W.	Evansville	Vanderburgh
Brodie, Donald W.	Indianapolis	Marion
Bromley, Luman W.	Fort Wayne	Allen
Bronson, Paul J.	Terre Haute	Vigo
Brooks, Fred R., Jr.	Indianapolis	Marion
Brooks, G. Tanner	Richmond	Wayne-Union
Brooks, Leonard C.	Warsaw	Kosciusko
Broomes, Edward L. C.	East Chicago	Lake
Brose, Paul E.	New York, N. Y.	Marion
Broshears, Kenneth P.	Linton	Greene
Brosius, Robert H. W.	Fort Wayne	Allen
Brown, Archie E.	Indianapolis	Marion
Brown, David B.	Gary	Lake
Brown, David E.	Indianapolis	Marion
Brown, DeWitt W.	Indianapolis	Marion
Brown, Earl R., Jr.	Kokomo	Howard
Brown, Frances T.	Indianapolis	Marion
Brown, Frank M.	Indianapolis	Marion
Brown, Frederic W.	Fort Wayne	Allen
Brown, George E.	Greenwood	Johnson
Brown, George W.	Evansville	Vanderburgh
Brown, Gordon T.	Indianapolis	Marion
Brown, James C.	Valparaiso	Porter
Brown, James M.	Anderson	Madison
Brown, John S.	Carlisle	Sullivan
Brown, Kenneth H.	New Albany	Floyd
Brown, Leland G.	Muncie	Delaware-Blackford
Brown, Leo R.	Gary	Lake
Brown, Marcel S.	Spencer	Owen-Monroe
Brown, Richard J.	Richmond	Wayne-Union
Brown, Robert M.	Marion	Grant
Brown, Robert R.	Terre Haute	Vigo
Brown, Stewart D.	Albany	Delaware-Blackford
Brown, Thomas M.	Muncie	Delaware-Blackford
Brown, Wendell E.	Indianapolis	Marion
Browning, James S.	Indianapolis	Marion
Browning, William M.	Indianapolis	Marion
Brownley, E. Jane	Indianapolis	Marion
Brubaker, Harold S.	Huntington	Huntington
Brubeck, Robert E.	Martinsville	Morgan
Bruce, Reginald A.	Indianapolis	Marion
Brucker, Perry A.	Fort Wayne	Allen
Brueckman, F. Robert	Indianapolis	Marion
Bruegge, Theodore J.	Kokomo	Howard
Bruetsch, Walter L.	Indianapolis	Marion
Bruner, Ralph W. (S)	Jeffersonville	Clark
Bryan, Franklin A.	Fort Wayne	Allen
Bryan, Robert E.	Kendallville	Noble
Bryan, Stanton L.	Evansville	Vanderburgh
Bryant, Edward G.	East Chicago	Lake
Buchanan, Wallace D.	South Bend	St. Joseph
Buche, Frederick P. (S)	Richmond	Wayne-Union
Buchman, Marshall H.	New Albany	Floyd
Buckingham, Richard E.	Bloomington	Owen-Monroe
Buckles, David L.	Anderson	Madison
Buckner, George D.	Fort Wayne	Allen

Name	City	County
Buckner, Joy F.	Bluffton	Wells
Buddrus, David J.	Evansville	Vanderburgh
Buechler, William F.	Elwood	Madison
Buechner, Frederick W.	South Bend	St. Joseph
Buehler, George M.	Jeffersonville	Clark
Buehner, Donald F.	Evansville	Vanderburgh
Buell, Forrest R.	Clay City	Clay
Bugh, Charles W.	Fairbanks, Alaska	Marion
Buhrmester, Harry C.	Lafayette	Tippecanoe
Bullers, Robert C.	Franklin	Johnson
Bullington, George E.	Whiteland	Johnson
Bunker, Ladoska Z.	North Manchester	Wabash
Burcham, James B.	Gary	Lake
Burdette, Harold F.	Indianapolis	Marion
Burger, Thomas C.	Evansville	Vanderburgh
Burghard, Rolla D.	Indianapolis	Marion
Burk, James M.	Decatur	Adams
Burket, Cecil R.	Bremen	Marshall
Burkhardt, Boyd A.	Tipton	Tipton
Burkhart, Charles A.	Fort Wayne	Allen
Burkle, Robert J.	Terre Haute	Vigo
Burks, Jess E.	Crawfordsville	Montgomery
Burnett, Arthur B.	New Castle	Henry
Burnett, Paul C.	Logansport	Cass
Burnikel, Ray H.	Evansville	Vanderburgh
Burns, John T.	Lafayette	Tippecanoe
Burns, Paul E.	Montpelier	Delaware-Blackford
Burress, Clyde R.	Evansville	Vanderburgh
Burwell, Stanley W.	Muncie	Delaware-Blackford
Bush, Charles E.	Kirklin	Clinton
Bush, Edward R.	Anderson	Madison
Bush, Hargis R.	Cannelton	Perry
Bush, Jack A.	Lafayette	Tippecanoe
Buslee, Roger M.	South Bend	St. Joseph
Bussard, Clifford F. (S)	South Bend	St. Joseph
Bussard, Frank W.	South Bend	St. Joseph
Butler, Joe B.	Crothersville	Jackson-Jennings
Butler, John O.	Indianapolis	Marion
Butler, Robert M.	Indianapolis	Marion
Butterfield, Robert M.	Muncie	Delaware-Blackford
Butts, Milton A.	South Bend	St. Joseph
Butz, Ralph O.	Muncie	Delaware-Blackford
Byrd, Ryland P.	Jeffersonville	Clark
Byrn, Howard W. (S)	Oxford	Floyd
Byrne, Louis E.	Bloomington	Owen-Monroe
Byrne, Robert J.	Bicknell	Knox

C

Cacia, John J.	Evansville	Vanderburgh
Cagle, Bob R.	New Palestine	Hancock
Cahn, Hugo M.	Indianapolis	Marion
Cahn, Peter H.	Indianapolis	Marion
Cahue, Antonio R.	Gary	Lake
Cain, David R.	New Castle	Henry
CaJacob, Melville E.	Terre Haute	Vigo
Caldwell, Marilyn R.	Indianapolis	Marion
Caldwell, Milton V.	Terre Haute	Vigo
Call, Herbert F.	Indianapolis	Marion
Call, William H.	Indianapolis	Marion
Callaghan, Winship C.	Greensburg	Decatur
Calli, Louis J.	North Vernon	Jackson-Jennings
Calvert, Raymond R.	Lafayette	Tippecanoe
Calvin, Helen M.	North Liberty	St. Joseph
Calvin, O. Walter	North Liberty	St. Joseph
Cameron, Don F.	Angola	Steuben
Cameron, Mary H.	Angola	Steuben
Campagna, Ettor A.	East Chicago	Lake
Campbell, H. Edwin, Jr.	Indianapolis	Marion
Campbell, John A.	Indianapolis	Marion
Campbell, Patrick B.	Elkhart	Elkhart
Campbell, Robert L.	Indianapolis	Marion
Campbell, Sam W.	Noblesville	Hamilton
Canaday, James W. (S)	Indianapolis	Marion
Canganelli, Vincent G.	Lafayette	Tippecanoe
Cannon, Daniel H.	New Albany	Floyd
Cantwell, Edgar R.	Indianapolis	Marion
Caplin, Irvin	Indianapolis	Marion
Caplin, Samuel S.	Indianapolis	Marion
Carberry, George A.	Gary	Lake
Carbone, Joseph A.	Gary	Lake
Carey, J. Albert	Gary	Lake
Carlberg, Dale L.	Jeffersonville	Clark
Carlo, Ernest R. (S)	Fort Wayne	Allen
Carlson, Edward A. (S)	Peru	Miami
Carlson, Milton R.	Portage	Porter
Carlson, Norman R.	Michigan City	La Porte
Carlson, Ralph F.	Evansville	Vanderburgh
Carlyle, Ivan E. (S)	Michigantown	Clinton
Carmody, Raymond F.	Gary	Lake
Carneal, Thomas E. (S)	Winamac	Pulaski
Carnes, Edwin R.	Clarksville	Clark
Carney, Joel T. (S)	Jeffersonville	Clark
Carpenter, Bennie F.	Griffith	Lake
Carpenter, James B.	Lafayette	Tippecanoe
Carpenter, Ramesh S.	Garrett	DeKalb
Carpentier, Harry F.	Princeton	Gibson
Carpentier, James R.	La Porte	La Porte
Carr, Joseph H.	Henryville	Clark
Carrel, Francis E.	Frankfort	Clinton
Carroll, Bertha Rose	W. Lafayette	Tippecanoe
Carroll, John C.	Decatur	Adams
Carroll, Mary E.	Crown Point	Lake
Carson, Wayne	Indianapolis	Marion
Carter, Eunice M.	Noblesville	Hamilton
Carter, F. R. N. (S)	South Bend	St. Joseph
Carter, Fred S.	La Porte	La Porte
Carter, James E.	Indianapolis	Marion
Carter, Jean V.	Tipton	Tipton
Carter, John O.	Hobart	Lake
Carter, Oren E.	Indianapolis	Marion
Carter, William D.	Walkerton	La Porte
Cartwright, Emor L. (S)	Fort Wayne	Allen
Cartwright, Jack D.	La Porte	La Porte
Carty, Charles B.	Pekin	Washington
Casey, Stanley M.	Huntington	Huntington
Cassady, James V.	South Bend	St. Joseph
Cassady, John R.	South Bend	St. Joseph
Cast, William R.	Indianapolis	Marion
Castetter, Gregory K.	Anderson	Madison
Castro, Ignacio B.	Scottsburg	Scott
Cattell, Lee M.	Kokomo	Howard
Cavins, Alexander W.	Terre Haute	Vigo
Caylor, Charles H.	Bluffton	Wells
Caylor, Harold D.	Bluffton	Wells
Caylor, Truman E.	Bluffton	Wells
Chael, Thomas C.	Munster	Lake
Challman, William B.	Mt. Vernon	Posey
Chambers, Alan R.	Fort Wayne	Allen
Chambers, Carol R.	Union City	Randolph
Chambers, Leroy B.	Union City	Randolph
Chamblee, Roland W.	South Bend	St. Joseph
Chandler, Leon H.	Goshen	Elkhart
Chappel, Alfred T.	Franklin	Johnson
Chase, James A.	Fort Wayne	Allen
Chase, Thomas P.	Avon	Hendricks
Chattin, Herbert O.	Vincennes	Knox
Chattin, Robert E.	Loogootee	Daviess-Martin
Chattin, William R.	Indianapolis	Marion
Chattin, Vance J.	Washington	Daviess-Martin
Chau, Andrew Y. S.	Terre Haute	Vigo
Cheesman, Donald D.	Danville	Hendricks
Chen, Ko K.	Indianapolis	Marion
Cheng, Sylvia F.	Logansport	Cass

Name	City	County
Chernish, Stanley M.	Indianapolis	Marion
Chevalier, Robert B.	Indianapolis	Marion
Childress, Richard H.	Indianapolis	Marion
Childs, Wallace E.	Madison	Jefferson-Switzerland
Chivington, Paul V.	Indianapolis	Marion
Choslovsky, Sydney	Gary	Lake
Christie, Marvin C.	Beech Grove	Marion
Christophel, Verna A.	Mishawaka	St. Joseph
Chroniak, Walter	Indianapolis	Marion
Chu, Johnson C. S.	Logansport	Cass
Chube, David D.	Gary	Lake
Church, Robert A.	Hammond	Lake
Ciatteo, Carmen T.	Munster	Lake
Clark, Charles M., Jr.	Indianapolis	Marion
Clark, George A.	Indianapolis	Marion
Clark, Ivan A.	Paoli	Orange
Clark, Jack P.	Syracuse	Elkhart
Clark, Joseph H.	Huntington	Huntington
Clark, Lawson J.	Indianapolis	Marion
Clark, Marion E.	Cambridge City	Henry
Clark, Robert M.	Muncie	Delaware-Blackford
Clark, Thomas W.	Evansville	Vanderburgh
Clark, William B., Jr.	Jeffersonville	Clark
Clark, William H.	South Bend	St. Joseph
Clark, William R.	Fort Wayne	Allen
Clarke, Elton R. (S)	Kokomo	Howard
Clarkson, Clarence G.	Liberty	Wayne-Union
Classen, Pete R. C.	Elkhart	Elkhart
Clay, Eleanor	Columbus	Bartholomew-Brown
Cleveland, John B.	Michigan City	La Porte
Clevinger, William G.	Indianapolis	Marion
Cline, Kenneth L.	Wyatt	St. Joseph
Close, Gerald A.	S. Rhodesia, Africa	Marion
Close, W. Donald	Indianapolis	Marion
Clouse, John F.	Muncie	Delaware-Blackford
Clouse, Paul A.	Evansville	Vanderburgh
Clunie, William A.	Huntington	Huntington
Coates, Jacqueline	Indianapolis	Marion
Cobb, Clarence M.	Logansport	Cass
Coble, Frank H.	Richmond	Wayne-Union
Cochran, Harry A., Jr.	Fort Wayne	Allen
Cochran, John F.	Bloomington	Owen-Monroe
Cochran, Robert B.	Muncie	Delaware-Blackford
Cockrum, William M.	Evansville	Vanderburgh
Coddens, Avery L.	Earl Park	Benton
Coddington, Robert C.	Ft. Campbell, Ky.	Marion
Coffel, Melvin H.	Vincennes	Knox
Coggeshall, Warren E.	Indianapolis	Marion
Cohen, Hyman	Gary	Lake
Cohen, Irving	Plainfield	Hendricks
Cohn, Alvin F.	Indianapolis	Marion
Colbert, Richard M.	Largo, Fla.	Marion
Colbert, Ruth E. D.	Largo, Fla.	Marion
Cole, Ira	Lafayette	Tippecanoe
Coleman, Floyd B.	Waterloo	DeKalb
Coleman, Henry G.	Salem	Washington
Coleman, Joseph E.	Evansville	Vanderburgh
Colip, George D.	South Bend	St. Joseph
Collins, Hubert L.	Indianapolis	Marion
Collins, Jack T.	Bluffton	Wells
Collins, Margaret C.	Muncie	Delaware-Blackford
Collins, Robert C.	Indianapolis	Marion
Colosey, Frederick J.	South Bend	St. Joseph
Colvin, Robert C.	Newburgh	Warrick
Combs, Herman T.	Evansville	Vanderburgh
Combs, John H.	Evansville	Vanderburgh
Combs, Stuart R.	Terre Haute	Vigo
Comeau, William J.	Marion	Grant
Comer, Kenneth E.	Mooresville	Morgan
Compton, George L.	Tipton	Tipton
Compton, Walter A.	Elkhart	Elkhart
Conforti, Victor P.	Terre Haute	Vigo
Congleton, G. C. (S)	Terre Haute	Vigo
Conklin, James O.	Terre Haute	Vigo
Conklin, Raymond L.	Elkhart	Elkhart
Conley, John E.	Fort Wayne	Allen
Conley, Joseph L. (S)	Indianapolis	Marion
Conley, Thomas M.	Kokomo	Howard
Connell, Vactor O.	Bourbon	Marshall
Connelly, Richard D.	Fort Wayne	Allen
Connerley, Marion L.	Terre Haute	Vigo
Connoy, Andrew F.	Westfield	Hamilton
Connoy, Leo F.	Westfield	Hamilton
Conrad, Henry W.	Lawrenceburg	Dearborn-Ohio
Constan, Evan	Westville	La Porte
Conway, Chester C.	Indianapolis	Marion
Conway, Glenn	Indianapolis	Marion
Conway, Thomas J.	Terre Haute	Vigo
Cook, Charles E.	North Manchester	Wabash
Cook, Gordon C.	South Bend	St. Joseph
Cook, Melvin D.	New Albany	Floyd
Cook, Robert G.	Bluffton	Wells
Cookson, Lawrence U.	Indianapolis	Marion
Cooney, Charles J.	Fort Wayne	Allen
Coons, John D. (S)	Lebanon	Boone
Coons, Ritchie	Lebanon	Boone
Cooper, B. Trent	Roanoke	Huntington
Cooper, Harry L. (S)	South Bend	St. Joseph
Cooper, John F.	Muncie	Delaware-Blackford
Cooper, Leo K.	Gary	Lake
Cooper, Waller W.	Evansville	Vanderburgh
Cope, Stanton E.	Huntington	Huntington
Corcoran, Patrick J. V.	Evansville	Vanderburgh
Cormican, Herbert L.	Elkhart	Elkhart
Cornacchione, Matthew	Indianapolis	Marion
Cornell, Robert A.	Crawfordsville	Montgomery
Corpe, Kenneth F.	Rushville	Rush
Corrao, Gaetano	Gary	Lake
Corrao, Thomas J.	Jeffersonville	Clark
Corsentino, Bart E.	Vincennes	Knox
Cortese, James V.	Indianapolis	Marion
Cortese, Thomas A.	Indianapolis	Marion
Costello, Albert J.	Hammond	Lake
Costin, Robert L.	Indianapolis	Marion
Cotter, Edward R.	Hammond	Lake
Cottrell, Robert F.	Fort Wayne	Allen
Coughenour, J. Robert	Indianapolis	Marion
Countryman, Frank W.	Indianapolis	Marion
Coursey, James O.	Plymouth	Marshall
Covalt, Wendell E.	Muncie	Delaware-Blackford
Covell, Harry M.	Auburn	DeKalb
Covey, Thomas J.	Valparaiso	Porter
Cox, Leon T.	Richmond	Wayne-Union
Coyner, Alfred B. (S)	Lafayette	Tippecanoe
Craft, Kenneth L. (S)	Indianapolis	Marion
Craig, Alexander F.	New Castle	Henry
Craig, Harry L.	Huntingburg	Dubois
Craig, Reuben	Kokomo	Howard
Craig, Reuben A. (S)	Kokomo	Howard
Craig, Richard M.	Fort Wayne	Allen
Craig, Robert A.	Syracuse	Elkhart
Crain, James W.	Williamsport	Fountain-Warren
Crampton, Chas. C. (S)	Delphi	Carroll
Crates, Gordon C.	Denver	Miami
Crawford, James H.	Evansville	Vanderburgh
Crawford, John A.	Indianapolis	Marion
Crawford, Theodore R.	Kokomo	Howard
Creek, Jean A.	Bloomington	Owen-Monroe
Cregger, Irby E.	Orlando AFB, Florida	Marion
Crevello, Albert J.	Evansville	Vanderburgh
Crimm, Paul D.	Evansville	Vanderburgh
Cripe, Earl P.	Bremen	Marshall

Name	City	County
Cripe, William H.	Portland	Jay
Crise, John R.	Portage	Porter
Crist, John R.	Mt. Vernon	Posey
Crockett, Franklin S. (H)	W. Lafayette	Tippecanoe
Crockett, Wayne A.	Terre Haute	Vigo
Cron, William J.	Warsaw	Kosciusko
Cronin, H. Joseph	Indianapolis	Marion
Cross, David G.	Indianapolis	Marion
Crowder, James H.	Sullivan	Sullivan
Crudden, Charles H.	Evansville	Vanderburgh
Crum, Marion M.	Angola	Steuben
Culbertson, Carl S.	South Bend	St. Joseph
Culbertson, Clyde G.	Indianapolis	Marion
Cullen, Paul K., Sr.	Indianapolis	Marion
Cullen, P. Kent, Jr.	Indianapolis	Marion
Cullison, John L.	Muncie	Delaware-Blackford
Cullnane, Chris W.	Evansville	Vanderburgh
Culloden, William G. (S)	Indianapolis	Marion
Culp, John E.	Fort Wayne	Allen
Cunningham, Gene C.	Indianapolis	Marion
Cunningham, Robert D.	Marion	Grant
Cure, Charles W.	Indianapolis	Marion
Cure, Elmer T.	Muncie	Delaware-Blackford
Currie, Robert W.	Indianapolis	Marion
Curry, R. Louis	Indianapolis	Marion
Curtner, Myron L. (S)	Vincennes	Knox
Custer, Edward W.	South Bend	St. Joseph
Cuthbert, Marvin P.	Indianapolis	Marion
Cymbala, Bohdan	Henderson, Ky.	Vanderburgh
Czenkusch, Helen G.	Indianapolis	Marion

D

Daggy, James R.	Richmond	Wayne-Union
Dahling, Clemens W.	New Haven	Allen
Dahling, Fred W.	New Haven	Allen
Dainko, Alfred J.	East Chicago	Lake
Dale, Maxwell H.	Connersville	Fayette-Franklin
Daley, Edward H.	Indianapolis	Marion
Dallas, Fred R.	Indianapolis	Marion
Dallas, Mary E.	Indianapolis	Marion
Dalton, William W.	Indianapolis	Marion
Dalton, Wilson L.	Shelbyville	Shelby
Daly, Joseph M.	Indianapolis	Marion
Daniel, John C. (S)	Indianapolis	Marion
Daniel, Robert A.	Gary	Lake
Daniels, George R. (S)	Marion	Grant
Dannacher, William D.	Wabash	Wabash
Dare, Lee A.	Jeffersonville	Clark
Darling, Dorothy R.	Gary	Lake
Das, Amal K.	New Castle	Henry
Dasaro, George E.	Gary	Lake
Datzman, Basil J.	La Porte	La Porte
Datzman, Richard C.	Fort Wayne	Allen
Daugherty, Forest D.	Columbus	Bartholomew-Brown
Daugherty, Fred N.	Crawfordsville	Montgomery
Daugherty, William L.	Hutsonville, Ill.	Sullivan
Daves, W. Lawrence	Evansville	Vanderburgh
David, George J.	Muncie	Delaware-Blackford
Davidoff, Manuel A.	Fort Wayne	Allen
Davidson, Dale A.	Indianapolis	Marion
Davidson, Harold H.	Evansville	Vanderburgh
Davidson, N. Cort	Indianapolis	Marion
Davis, Bennie L.	Indianapolis	Marion
Davis, Carl M.	Valparaiso	Porter
Davis, Claude E.	Angola	Steuben
Davis, Edgar C. (S)	Muncie	Delaware-Blackford
Davis, Edward A.	South Bend	St. Joseph
Davis, F. Sterling	Indianapolis	Marion
Davis, Grayson B.	Lafayette	Tippecanoe
Davis, Howard B.	Lafayette	Tippecanoe
Davis, John A.	Flat Rock	Shelby
Davis, Joseph B.	Marion	Grant
Davis, Lloyd H. (S)	Madison	Jefferson-Switzerland
Davis, Margaret M.	Indianapolis	Marion
Davis, Marvin R.	Columbus	Bartholomew-Brown
Davis, Max D.	Evansville	Vanderburgh
Davis, Merrill S. (S)	Marion	Grant
Davis, Neal	Gary	Lake
Davis, Paul E.	Terre Haute	Vigo
Davis, Richard M.	Marion	Grant
Davis, Sam J.	Indianapolis	Marion
Davis, Thomas N. III	Hammond	Lake
Day, William D. C.	Seymour	Jackson-Jennings
Deal, Eleanor H.	Speedway City	Marion
Dean, Donald I.	Rushville	Rush
Dearmin, Robert M.	Indianapolis	Marion
DeArmond, Murray	Indianapolis	Marion
De Bois, Elon	Gary	Lake
DeBrota, John, Jr.	Kokomo	Howard
Deems, Myers B.	Evansville	Vanderburgh
Deever, John W.	Indianapolis	Marion
DeFries, John J.	New Paris	Elkhart
DeGrazia, Eugene J.	Valparaiso	Porter
Dehner, John R.	Indianapolis	Marion
Deitch, Robert D.	Indianapolis	Marion
DeMotte, C. Bowen	Greenwood	Marion
DeNaut, James F.	Knox	Starke
Denham, Robert H.	South Bend	St. Joseph
Dennison, Alfred D., Jr.	Indianapolis	Marion
Denny, E. Rankin	Cape Canaveral, Fla.	Vigo
Denny, Forrest L.	Indianapolis	Marion
Denny, James W.	Indianapolis	Marion
Denton, Larkin D.	Greentown	Howard
Denzer, Edward K.	Evansville	Vanderburgh
Denzer, William O.	Evansville	Vanderburgh
Deppe, Charles F.	Franklin	Johnson
Deren, Matthew J.	La Porte	La Porte
Derhammer, George L.	Brookston	Tippecanoe
Dester, Herbert E. (S)	Berne	Adams
DeTar, George B. (S)	Moore Haven, Fla.	Pike
Dettloff, Frederick R.	Greencastle	Putnam
Deur, Julius J.	Lafayette	Tippecanoe
Deutsch, William	Muncie	Delaware-Blackford
DeVoe, Kenneth R.	South Bend	St. Joseph
DeWees, Dwight L.	Indianapolis	Marion
DeWester, Gerald M.	Indianapolis	Marion
Dian, August J.	Gary	Lake
Dickerson, W. Martin	Monticello	White
Dickson, Carolyn L.	Indianapolis	Marion
Dickson, Dale D.	Greensburg	Decatur
Dieckman, Herbert S.	Evansville	Vanderburgh
Dielman, Franklin C. (S)	Fulton	Fulton
Dierdorf, Fred W.	Terre Haute	Vigo
Dierolf, Edward J.	Gary	Lake
Dieter, William J.	Westville	La Porte
Dietl, Ernest L.	South Bend	St. Joseph
Dietz, David J.	Muncie	Delaware-Blackford
Dill, Charles W.	Beech Grove	Marion
Dill, Myron K.	Indianapolis	Marion
Dillman, Carl E.	Corydon	Harrison-Crawford
Dilts, Robert L.	Indianapolis	Marion
Dimitroff, Lambro	Calumet City, Ill.	Lake
Dimmett, James D.	Boonville	Warrick

Name	City	County
Dingle, Paul E.	Richmond	Wayne-Union
Dingley, Albert F.	South Bend	St. Joseph
Dininger, William S.	Winchester	Randolph
Dintaman, Paul G.	Indianapolis	Marion
Dirks, Kenneth R.	Ft. Detrick, Md.	Marion
Disney, Charles T.	Gary	Lake
Dittmer, Jack E.	Valparaiso	Porter
Dittmer, Thomas L.	Valparaiso	Porter
Ditton, Irvin W. (S)	Fort Wayne	Allen
Dixon, Rex W.	Anderson	Madison
Doan, John E.	Decatur	Adams
Dodd, Robert D.	South Bend	St. Joseph
Dodd, Roberts K.	Evansville	Vanderburgh
Dodds, James U.	Hartford City	Delaware-Blackford
Dodds, Wemple	Crawfordsville	Montgomery
Doenges, James L.	Anderson	Madison
Doermann, Paul E.	Huntington	Huntington
Doherty, Raymond J.	Crown Point	Lake
Dolan, Patrick A.	Indianapolis	Marion
Doles, Ted S.	Middletown	Delaware-Blackford
Dolezal, Bernard J.	South Bend	St. Joseph
Donahue, Claude M.	Carmel	Hamilton
Donahue, Francis E.	Dublin	Henry
Donahue, George R.	Lafayette	Tippecanoe
Donahue, James M.	APO 851, New York, N. Y.	Marion
Donaldson, Frank C.	Anderson	Madison
Donaldson, Miles W.	Marion	Grant
Donato, Albert M.	Indianapolis	Marion
Donchess, Joseph C.	Gary	Lake
Doneff, Ronald H.	Hobart	Lake
Donnally, George A.	Portland	Jay
Donnelly, Everett F.	South Bend	St. Joseph
Doran, J. Hal	Indianapolis	Marion
Dormire, Robert D.	Warsaw	Koscuisko
Dorrance, Thomas O.	Bluffton	Wells
Doss, Jerome F.	Forbes AFB, Kansas	Marion
Doughty, Samuel R., Jr.	Indianapolis	Marion
Douglas, William T.	Indianapolis	Marion
Dovey, Edward G.	Elkhart	Elkhart
Dowd, Joseph A.	Indianapolis	Marion
Dowell, Emil H.	Rockville	Parke-Vermillion
Downer, Luther H.	Evansville	Vanderburgh
Dragoo, John R.	Wabash	Wabash
Drake, Dale W.	Evansville	Vanderburgh
Drake, Ellery T.	Martinsville	Morgan
Drake, James R.	Anderson	Madison
Drake, John C.	Anderson	Madison
Drake, Marion C.	Elwood	Madison
Drennen, Robert V.	Anderson	Madison
Drew, Arthur L., Jr.	Indianapolis	Marion
Dreyer, Ralph W.	Richmond	Wayne-Union
Drummy, William W.	Terre Haute	Vigo
Dryden, Gale E.	Indianapolis	Marion
Dublin, Madeline P.	Francesville	Tippecanoe
DuBois, Charles C. (S)	Warsaw	Kosciusko
DuBois, Ramon B.	Lafayette	Tippecanoe
Dudgeon, Charles A.	Hartford City	Delaware-Blackford
Duemling, Arnold H.	Fort Wayne	Allen
Dugan, Thomas	Columbus	Bartholomew-Brown
Dukes, Betty	Dugger	Sullivan
Dukes, David A.	Tell City	Perry
Dukes, David J.	Corydon	Harrison-Crawford
Dukes, Frederic M. (S)	Dugger	Sullivan
Dukes, Joe E.	Dugger	Sullivan
Dulin, Basil B.	Anderson	Madison
Dumanian, Ara V.	Homewood, Ill.	Lake
Dunbar, Fred E.	Marion	Grant
Duncan, John S.	Gary	Lake
Duncan, Raymond	Bedford	Lawrence
Duncan, Stuart J.	Indianapolis	Marion
Duncan, William A.	Indianapolis	Marion
Dunham, Henry H.	Roann	Wabash
Dunkin, Ramon S.	Indianapolis	Marion
Dunlap, D. Logan	South Bend	St. Joseph
Dunning, Thomas W.	Muncie	Delaware-Blackford
Dunstone, Harry C.	Fort Wayne	Allen
Dupes, Lowell E.	Indianapolis	Marion
Dupler, Lee F.	Indianapolis	Marion
Durham, Lowell J.	La Porte	La Porte
Durham, Thomas E.	Elkhart	Elkhart
Durkee, Melvin S.	Evansville	Vanderburgh
Durkin, John W., Jr.	Evansville	Vanderburgh
Dusard, Joseph C.	Bedford	Lawrence
DuSold, Donald D.	Crown Point	Lake
Dutchess, C. Toney	Galveston	Cass
Dutchman, William R.	Muncie	Delaware-Blackford
Dyar, Edwin W.	Indianapolis	Marion
Dycus, Walter A.	Evansville	Vanderburgh
Dye, Cloyd L.	New Castle	Henry
Dye, William E.	Oakland City	Gibson
Dyer, George W.	Terre Haute	Vigo
Dyer, Wallace K.	Evansville	Vanderburgh
Dyke, Richard W.	Indianapolis	Marion
Dyken, Mark L.	Indianapolis	Marion
Dyken, Paul R.	St. Louis, Mo.	Marion
Dykhuizen, Theodore A.	Frankfort	Clinton
Dzenitis, Andrievs J.	Indianapolis	Marion
Dziabis, Marvin D.	Indianapolis	Marion

E

Eades, R. Charles	South Bend	St. Joseph
Eades, Ralph C.	Valparaiso	Porter
Earl, Max M.	Kokomo	Howard
Earp, Evanson B.	Indianapolis	Marion
Easter, James N.	New Castle	Henry
Eastman, Joseph R., Jr.	Indianapolis	Marion
Eaton, Edwin R.	Indianapolis	Marion
Eaton, Lyman D.	Indianapolis	Marion
Eaton, Marion J.	Lafayette	Tippecanoe
Ebbinghouse, Tom	Richmond	Wayne-Union
Ebert J. Wayne	Indianapolis	Marion
Eberwein, John H. (S)	Indianapolis	Marion
Ebin, Judah L.	Evansville	Vanderburgh
Echeverria, Rodolfo E.	Elkhart	Elkhart
Echsner, Herman J.	Columbus	Bartholomew-Brown
Echt, Charles R.	Indianapolis	Marion
Eckberg, Theodore J.	Memphis, Tenn.	Marion
Eckert, Russell A.	Logansport	Cass
Edmonds, Kendrick	Bedford	Lawrence
Edwards, Bernard E.	South Bend	St. Joseph
Edwards, Edward T.	Vincennes	Knox
Edwards, Henry G.	Terre Haute	Vigo
Edwards, William F.	New Albany	Floyd
Egan, Sherman L.	South Bend	St. Joseph
Egan, Robert L.	Indianapolis	Marion
Egbert, Herbert L.	Indianapolis	Marion
Egger, Ross L.	Middletown	Delaware-Blackford
Eggers, Ernest L. (S)	Hammond	Lake
Eggers, Henry W.	Hammond	Lake
Eggers, Richard	Crawfordsville	Montgomery
Egnatz, Charles D.	Fort Ord, Calif.	Lake
Egnatz, Nicholas	Hammond	Lake
Ehrich, William S. (S)	Manning, S.Carolina	Vanderburgh
Eicher, Palmer O.	Indianapolis	Marion
Eikenberry, Hugh W.	Indianapolis	Marion
Eiler, Paul A.	North Manchester	Wabash

Name	City	County
Eisaman, Jack L.	Bluffton	Wells
Eisenberg, David A.	Martinsville	Morgan
Eisterhold, John A.	Evansville	Vanderburgh
Eldridge, Gail E.	Indianapolis	Marion
Elkins, James P.	Indianapolis	Marion
Elledge, Ray (S)	Hammond	Lake
Elleman, John H.	Kokomo	Howard
Ellett, John, Jr.	Coatesville	Putnam
Elliott, Paul W.	Lafayette	Tippecanoe
Elliott, Thomas A.	Elkhart	Elkhart
Ellis, Davis W.	Rushville	Rush
Ellis, Forrest D.	North Vernon	Jackson-Jennings
Ellis, George M.	Connersville	Fayette-Franklin
Ellis, Lyman H.	Lizton	Hendricks
Ellis, Seth W.	Anderson	Madison
Ellis, William N.	Indianapolis	Marion
Elshout, Clem H.	Ann Arbor, Mich.	La Porte
Elsten, Aubrey, W.	Anderson	Madison
Elston, Lynn W.	Fort Wayne	Allen
Elston, Ralph W.	Fort Wayne	Allen
Elward, Carl J.	Wabash	Wabash
Ely, Cecil W.	Jeffersonville	Clark
Emenhiser, Donald C.	New Haven	Allen
Emenhiser, John L.	Fort Wayne	Allen
Emery, Charles B.	Bedford	Lawrence
Emery, Charles B., Jr.	Bloomington	Owen-Monroe
Emhardt, John T.	Indianapolis	Marion
Emhardt, John W. A. (S)	Indianapolis	Marion
Emme, Richard W.	Harlan	Allen
Endicott, Wayne H.	Greenfield	Hancock
Engel, Edgar L.	Evansville	Vanderburgh
Engel, Howard R.	South Bend	St. Joseph
Engeler, James E.	Lafayette	Tippecanoe
Engle, Russell B.	Winchester	Randolph
Engleman, Reinhold	Fort Wayne	Allen
English, Hubert M.	Gary	Lake
English, John P.	South Bend	St. Joseph
Entner, Charles L.	Dunkirk	Jay
Episcopo, Arsenius R.	Salem	Washington
Erdel, Milton W.	Frankfort	Clinton
Erehart, Mark G. (S)	Huntington	Huntington
Erhart, Hubert	Ferdinand	Dubois
Ericksen, Lester G.	South Bend	St. Joseph
Erickson, Gustaf W.	South Bend	St. Joseph
Ericson, Harold L.	Windfall	Tipton
Ericson, Homer S.	Kokomo	Howard
Erwin, W. Robert	La Porte	La Porte
Eshelman, Henry R.	Monterey	Pulaski
Eskew, Kenneth W.	Sullivan	Sullivan
Espino, Jose C.	Munster	Lake
Espy, Theodore R.	Gary	Lake
Eugenides, Tatiana	Highland	Lake
Evans, Daniel R.	Indianapolis	Marion
Evans, Frederick H.	Indianapolis	Marion
Evans, Frederick J.	Clinton	Parke-Vermillion
Evans, Paul V.	Indianapolis	Marion
Everly, Ralph V.	Indianapolis	Marion
Eviston, John B. (S)	Huntington	Huntington
Ewer, Robert W.	Evansville	Vanderburgh
Ewing, Nathaniel D.	Vincennes	Knox

F

Fadell, Matthew J.	Gary	Lake
Fadul, Armand	Crown Point	Lake
Failey, Robert B.	Indianapolis	Marion
Faith, Ira L.	Evansville	Vanderburgh
Fargher, Francis M.	Michigan City	La Porte
Farid, Rahim S.	Brazil	Clay
Farner, James E.	Mishawaka	St. Joseph
Farnsworth, Samuel A.	La Porte	La Porte
Farquhar, John S., Jr.	Fort Wayne	Allen
Farr, James C.	Bloomington	Owen-Monroe
Farrell, John J., Jr.	Greenfield	Hancock
Farrell, Joseph T.	Indianapolis	Marion
Farris, John J.	Washington	Daviess-Martin
Faul, Henry J.	Evansville	Vanderburgh
Faulkner, Donald J.	Hobart	Lake
Fausset, C. Basil	Indianapolis	Marion
Faust, Howard M., Jr.	Anderson	Madison
Faw, Melvin L.	Evansville	Vanderburgh
Fedor, Thomas A.	East Chicago	Lake
Feeney, Martin T.	Indianapolis	Marion
Feferman, Martin E.	South Bend	St. Joseph
Feinberg, Irwin I.	Whiting	Lake
Feinn, Harry S.	La Porte	La Porte
Feldman, Max	South Bend	St. Joseph
Feldner, Ronald P.	Calumet City, Ill.	Lake
Fell, Robert M.	Rosedale	Parke-Vermillion
Fenneman, Robert J.	Evansville	Vanderburgh
Ferguson, Arthur N.	Fort Wayne	Allen
Ferguson, Donald H.	Anderson	Madison
Ferguson, William B.	Lafayette	Tippecanoe
Ferrara, Donald W.	Peru	Miami
Ferrara, Joseph F.	Franklin	Johnson
Ferrara, Samuel J.	Peru	Miami
Ferrell, Mars B.	Fortville	Madison
Ferry, Francis A.	Indianapolis	Marion
Ferry, John L.	Whiting	Lake
Ferry, Paul W. (S)	Kokomo	Howard
Fessler, Gordon S.	Rising Sun	Dearborn-Ohio
Fetrow, Kenneth O.	Munster	Lake
Fichman, Abraham M.	Fort Wayne	Allen
Fickas, Dallas	Evansville	Vanderburgh
Fiederlein, Frederick J.	Muncie	Delaware-Blackford
Fields, Donald C.	Lafayette	Tippecanoe
Fields, Donald L.	Kokomo	Howard
Filipek, Walter J.	South Bend	St. Joseph
Finfrock, James D.	Elkhart	Elkhart
Finneran, Joseph C.	Indianapolis	Marion
Fipp, August L.	Rome City	Noble
Firestein, Ben Z.	South Bend	St. Joseph
Firestein, Ray	South Bend	St. Joseph
Fisch, Charles	Indianapolis	Marion
Fischer, A. Alan	Indianapolis	Marion
Fischer, Burnell	Hammond	Lake
Fischer, Carlton N.	La Porte	La Porte
Fischer, Warren E.	Anderson	Madison
Fish, Clyde M. (S)	Edwardsburg, Mich.	St. Joseph
Fish, Edson C.	South Bend	St. Joseph
Fisher, Frank C.	Buffalo, N. Y.	Marion
Fisher, Gerald E.	Ippy, Central African Republic	Marion
Fisher, Henry	Marion	Grant
Fisher, John E.	Attica	Fountain-Warren
Fisher, John E.	New Castle	Henry
Fisher, Lawrence F. (S)	South Bend	St. Joseph
Fisher, Noreen M.	Indianapolis	Marion
Fisher, Walter S.	Columbus	Bartholomew-Brown
Fisher, William C.	Evansville	Vanderburgh
Fitzgerald, Brice E.	Logansport	Cass
Fitzgerald, William J.	Indianapolis	Marion
Fitzpatrick, H. W. (S)	Elwood	Madison
Fitzpatrick, James S.	Portland	Jay
Fitzpatrick, William J.	Hammond	Lake
Flack, Russell A.	Lafayette	Tippecanoe
Flaherty, Robert A.	Fort Wayne	Allen
Flanagan, Estle P. (S)	Walton	Cass
Flanagan, Paul M.	Indianapolis	Marion
Flanders, Robert	Indianapolis	Marion
Flanigan, Meredith B.	Indianapolis	Marion
Flannigan, Harley F.	LaGrange	LaGrange

Name	City	County
Fleischer, Jacob C.	East Chicago	Lake
Fleischl, Herbert	Indianapolis	Marion
Fleming, Claude F. (S)	Elkhart	Elkhart
Flick, John J.	Indianapolis	Marion
Flora, Fred W.	Frankfort	Clinton
Flora, Joseph O.	Indianapolis	Marion
Fogel, Ernest J.	Logansport	Cass
Folck, John K.	Princeton	Gibson
Foley, Hansel O.	South Bend	St. Joseph
Folkening, Norval C.	Indianapolis	Marion
Foltz, Lloyd E.	Brownsburg	Hendricks
Fong, Theodore C. C.	Madison	Jefferson-Switzerland
Forbes, Robert S.	Indianapolis	Marion
Forbes, Violet Crabbe	Wolcott	White
Foreman, Walter A.	Brookville	Fayette-Franklin
Forrest, O. Norman, Jr.	South Bend	St. Joseph
Forry, Frank (S)	Indianapolis	Marion
Forsee, Norman E.	Jeffersonville	Clark
Fortuna, Frank W.	Indianapolis	Marion
Fosbrink, Ephraim L.	Syracuse	Elkhart
Fosgate, Harold L.	Indianapolis	Marion
Foster, Douglas L.	Topeka, Kans.	Lake
Foster, Lee N.	Indianapolis	Marion
Foster, Ray D.	Indianapolis	Marion
Foster, Ray T.	New Castle	Henry
Foster, Robert H. K.	Franklin	Johnson
Fountaine, Thomas J.	Bedford	Lawrence
Fouts, Paul J.	Indianapolis	Marion
Fowler, Richard R.	Bloomington	Owen-Monroe
Fox, C. Philip	Washington	Daviess-Martin
Fox, Jack M.	Munster	Lake
Fox, Richard F.	Lafayette	Tippecanoe
Frable, Frank L., Jr.	Lawrenceburg	Dearborn-Ohio
Frahm, Charles	East Chicago	Lake
France, Lloyd C.	Plymouth	Marshall
Frank, Herbert	South Bend	St. Joseph
Frank, John R. (S)	Valparaiso	Porter
Frank, Lyall, Jr.	South Bend	St. Joseph
Frank, Lyall L.	South Bend	St. Joseph
Franke, Gordon R.	Fort Wayne	Allen
Frankhouser, Charles M. A.	Fort Wayne	Allen
Franklin, William L.	Indianapolis	Marion
Frankowski, Clementine	Whiting	Lake
Frantz, Mount E.	Danville	Hendricks
Frasch, Mahlon G.	Lafayette	Tippecanoe
Frash, DeVon W., Jr.	South Bend	St. Joseph
Frash, DeVon W.	South Bend	St. Joseph
Frazier, John L.	Kokomo	Howard
Freeborn, Warren S., Jr.	Oaklandon	Hancock
Freeby, C. William	Decatur	Adams
Freed, Carl A.	Indianapolis	Marion
Freed, John E., Jr.	Terre Haute	Vigo
Freeland, Bill E.	Batesville	Ripley
Freeman, Leslie W.	Indianapolis	Marion
Freeman, Max E.	Indianapolis	Marion
French, Richard N.	Indianapolis	Marion
Fretz, Richard C.	Kokomo	Howard
Frey, Harley H., Jr.	Lafayette	Tippecanoe
Frey, William B.	South Bend	St. Joseph
Friedman, Isadore E.	Hammond	Lake
Friedman, Morris S.	South Bend	St. Joseph
Frith, Louis G.	South Bend	St. Joseph
Fromhold, Willis A.	Indianapolis	Marion
Frost, Robert J.	Michigan City	La Porte
Fry, Robert D.	Indianapolis	Marion
Fuelling, James L.	Marion	Grant
Fullam, Richard G.	Fort Wayne	Allen
Fuller, Robert G.	Columbus	Bartholomew-Brown
Fullerton, Robert L.	Monticello	White
Fulton, William H.	Indianapolis	Marion
Fultz, Roy L.	Salem	Washington
Funkhouser, Elmer (S)	Indianapolis	Marion
Furr, Jack D.	Kingman	Fountain-Warren
Futterknecht, James O.	Elkhart	Elkhart

G

Gabe, William E.	Orinda, Calif.	Marion
Gabovitch, Edward R.	Indianapolis	Marion
Gabrielsen, Ted H.	APO 31, San Francisco, Calif.	Marion
Gaddy, Euclid T.	Indianapolis	Marion
Gaddy, Nelson D.	Indianapolis	Marion
Gaffney, Raymond	South Bend	St. Joseph
Gahimer, Joe E.	Anderson	Madison
Gailey, Ivan L.	Clinton	Parke-Vermillion
Galante, Vincent J.	Gary	Lake
Galbreth, Jesse P. (S)	Burnettsville	White
Galliher, Marjorie J.	Muncie	Delaware-Blackford
Gallinatti, John J.	Gary	Lake
Galloway, John A.	Indianapolis	Marion
Gambill, J. Randolph	Indianapolis	Marion
Gambill, William D.	Indianapolis	Marion
Gammieri, Robert L.	Indianapolis	Marion
Gammell, Lindley L.	Columbus	Bartholomew-Brown
Ganser, Ralph V.	South Bend	St. Joseph
Ganser, Richard A.	Mishawaka	St. Joseph
Gante, Henry W. (S)	Anderson	Madison
Ganz, Max	Marion	Grant
Garber, J. Neill	Indianapolis	Marion
Garceau, George J.	Indianapolis	Marion
Gard, Daniel A.	Indianapolis	Marion
Gardiner, H. Glenn	East Chicago	Lake
Gardiner, Sprague H.	Indianapolis	Marion
Gardner, Austin L.	Indianapolis	Marion
Gardner, Buckman	Indianapolis	Marion
Gardner, Melvin D.	Michigan City	La Porte
Gardner, Russell A.	Michigan City	La Porte
Garfield, Martin D.	Indianapolis	Marion
Garland, Edgar A.	Evansville	Vanderburgh
Garling, Luvern C.	Muncie	Delaware-Blackford
Garner, W. Stanley	Indianapolis	Marion
Garner, William H., Jr.	New Albany	Floyd
Garner, William H., Sr.	New Albany	Floyd
Garrett, John D. (S)	Indianapolis	Marion
Garrett, Robert A.	Indianapolis	Marion
Garrison, James L.	Cumberland	Hancock
Garrison, Leon J.	Gas City	Grant
Garst, Garland R.	Evansville	Vanderburgh
Garton, Harry W.	Fort Wayne	Allen
Garvin, Donald B.	Brazil	Clay
Gastineau, David C.	Fort Wayne	Allen
Gates, George E.	South Bend	St. Joseph
Gattman, George B.	Elkhart	Elkhart
Gatzimos, Christos D.	Logansport	Cass
Gaul, L. Edward	Evansville	Vanderburgh
Gaunt, Everett W.	Alexandria	Madison
Geckler, Charles E.	Muncie	Delaware-Blackford
Geick, Raymond G.	Fort Branch	Gibson
Geider, Roy A.	Indianapolis	Marion
Geiger, Dillon D.	Bloomington	Owen-Monroe
Geisinger, Lewis N. (S)	Auburn	De Kalb
Geisler, Hans E.	New York, N. Y.	Marion
Geller, Samuel	Evansville	Vanderburgh
Genna, Mary E. Miller	Indianapolis	Marion
Gentile, John P.	New Albany	Floyd
Gentile, Jonathan P.	Fort Wayne	Allen
George, Charles L.	Indianapolis	Marion
Gerding, William J.	Fort Wayne	Allen
Gerig, Eldon L.	Mishawaka	St. Joseph
Geronimo, Rita R. V.	East Chicago	Lake
Gerrish, Donald A.	Terre Haute	Vigo

Name	City	County
Gery, Richard E.	Lafayette	Tippecanoe
Getty, William H.	Evansville	Vanderburgh
Gevirtz, Milton B.	Hammond	Lake
Geyer, Joseph H.	New Albany	Floyd
Gibbs, Charles M. (S)	Warren	Hancock
Gibbs, Joseph W.	Martinsville	Hendricks
Gibson, Alois E.	Richmond	Wayne-Union
Gibson, Greta Maxine	Indianapolis	Marion
Gibson, Robert K.	Muncie	Delaware-Blackford
Gick, Herman H. (S)	Indianapolis	Marion
Giffin, Charles S.	Fort Wayne	Allen
Gifford, Fred E.	Indianapolis	Marion
Gilbert, Robert G.	Tell City	Perry
Gill, Dee D.	Leesburg	Kosciusko
Gill, Donald R.	Huntington	Huntington
Gill, Thomas A.	Muncie	Delaware-Blackford
Gilles, Pierre	Gary	Lake
Gillespie, Charles F.	Indianapolis	Marion
Gillespie, Garland R.	Brownstown	Jackson-Jennings
Gillespie, Jacob E.	Indianapolis	Marion
Gilliland, John E.	Puerto Cabezas, Nicaragua	Marion
Gillim, Parvin D.	Indianapolis	Marion
Gillotte, Joseph P.	Terre Haute	Vigo
Gillum, Eugene M.	Portland	Jay
Gilman, Marcus M.	South Bend	St. Joseph
Gilmore, Robert W.	Michigan City	La Porte
Gilmore, Russell A. (S)	Michigan City	La Porte
Gingerick, Charles M.	Liberty Center	Wells
Ginsberg, Stewart T.	Indianapolis	Marion
Giorgio, Douglas J.	Evansville	Vanderburgh
Girod, Arthur H.	Decatur	Adams
Gish, Howard M.	Brookston	Tippecanoe
Gitlin, Max M.	Bluffton	Wells
Gitlin, William A.	Bluffton	Wells
Given, Everett H.	Michigan City	La Porte
Glackman, John C., Jr.	Rockport	Spencer
Gladstone, Naf H.	Fort Wayne	Allen
Glassley, Stephen H.	Fort Wayne	Allen
Glendening, John L. (S)	Indianapolis	Marion
Glendening, Richard L.	Logansport	Cass
Glock, Homer E. (S)	Fort Wayne	Allen
Glock, Maurice E.	Fort Wayne	Allen
Glock, Wayne R.	Fort Wayne	Allen
Glover, John L.	Indianapolis	Marion
Glover, William J.	Gary	Lake
Gobbel, Novy E. (S)	English	Harrison-Crawford
Godwin, Donald W.	Indianapolis	Marion
Goebel, Carl W.	Fort Wayne	Allen
Godersky, George E.	South Bend	St. Joseph
Goethals, Charles J.	Mishawaka	St. Joseph
Gold, Marvin E.	Valparaiso	Porter
Goldberg, Harold B.	Gary	Lake
Golding, Robert F.	Gary	Lake
Goldman, Samuel	Indianapolis	Marion
Goldsmith, David A.	Marion	Grant
Goldstone, Adolph	Gary	Lake
Goldstone, Arthur	Gary	Lake
Goldstone, Joseph	Gary	Lake
Goldstone, Robert J.	Gary	Lake
Goldstone, Sidney R.	Gary	Lake
Golper, Marvin N.	Kokomo	Howard
Good, Richard P.	Kokomo	Howard
Gooding, Richard A.	Indianapolis	Marion
Goodman, Eli	Charlestown	Clark
Goodman, Hubert T.	Terre Haute	Vigo
Goodrum, William R.	Cayuga	Parke-Vermillion
Goodwin, Thomas	Gary	Lake
Gootee, Francis H.	Jasper	Dubois
Gootee, Thomas H.	Jasper	Dubois
Gordon, Joseph L.	Wheeler	Porter
Gormley, Joseph J.	Indianapolis	Marion
Gosman, James H.	Indianapolis	Marion
Gossard, Meredith B.	Tipton	Tipton
Gossom, Donn R.	Terre Haute	Vigo
Gould, John C.	Fort Wayne	Allen
Gourieux, E. De Verre	Evansville	Vanderburgh
Govorchin, Alexander	East Chicago	Lake
Graber, Virgil R.	Elkhart	Elkhart
Graessle, Harold P. (S)	Seymour	Jackson-Jennings
Graf, Jerome A.	Bloomfield	Greene
Graf, John P.	South Bend	St. Joseph
Graham, Edward W.	Indianapolis	Marion
Graham, George M.	Fort Wayne	Allen
Graham, James C.	Fort Wayne	Allen
Graham, John D.	Indianapolis	Marion
Graham, William E.	Alexandria, La.	Marion
Grant, Benjamin F.	Gary	Lake
Grant, M. Arthur	Marion	Grant
Grant, Phyllis A.	New Castle	Henry
Graves, Noel S.	Vevay	Jefferson-Switzerland
Graves, Orville M. (S)	Princeton	Gibson
Gray, Clyde C. (S)	Cloverdale	Putnam
Gray, Daniel E.	Crown Point	Lake
Gray, Edwin H.	Elkhart	Elkhart
Gray, Kenneth L.	Indianapolis	Marion
Gray, Leon	Martinsville	Morgan
Gray, Mary Case	Elkhart	Elkhart
Gray, William J.	Anderson	Delaware-Blackford
Grayson, Ted L.	Indianapolis	Marion
Grayston, Wallace S. (S)	Huntington	Huntington
Green, Frank H.	Rushville	Rush
Green, G. Richard	South Bend	St. Joseph
Green, George F.	South Bend	St. Joseph
Green, Leonard J.	Valparaiso	Porter
Green, Morris	Indianapolis	Marion
Green, Norval E.	South Bend	St. Joseph
Green, Robert F.	Fort Wayne	Allen
Green, William L.	Shelbyville	Shelby
Greenburg, Louis T.	Evansville	Vanderburgh
Greene, Frederick G. (S)	Seelyville	Parke-Vermillion
Greene, Morgan E.	Indianapolis	Marion
Greene, Robert W.	Rensselaer	Jasper
Greene, William R.	Henryville	Clark
Greenlee, Robert L.	Fort Wayne	Allen
Gregg, Albert F.	Connersville	Fayette-Franklin
Gregg, Edwin E.	Thorntown	Boone
Gregoline, Amadeo F.	Gary	Lake
Gregoline, Eugene	Gary	Lake
Gregory, Robert L.	Indianapolis	Marion
Greiber, Marvin F.	Muncie	Delaware-Blackford
Greisen, Jack G.	Whiting	Lake
Greist, John H.	Indianapolis	Marion
Gresham, Edwin L.	Aurora	Dearborn-Ohio
Griep, Arthur H.	Evansville	Vanderburgh
Griest, Walter D.	Fort Wayne	Allen
Griffin, Charles G.	Valparaiso	Porter
Griffin, Joseph P.	Chesterton	Porter
Griffin, Leslie W.	Indianapolis	Marion
Griffith, Harold R.	Fort Wayne	Allen
Griffith, James W.	Sheridan	Hamilton
Griffith, Richard S.	Indianapolis	Marion
Griffith, Ross E.	Indianapolis	Marion
Griffith, Thomas E.	Hammond	Lake
Grigsby, Hardin B.	Lebanon	Boone
Grillo, Donald	South Bend	St. Joseph
Grimes, Hubert N.	Indianapolis	Marion
Grimm, William C. H.	Evansville	Vanderburgh
Gripe, Richard P.	Lafayette	Tippecanoe
Grisell, Ted L.	Indianapolis	Marion
Grosso, William G.	East Chicago	Lake
Grorud, Alton C.	South Bend	St. Joseph

Name	City	County
Grosz, Hanus J.	Indianapolis	Marion
Grothouse, Carl B.	Kokomo	Howard
Grove, James H.	South Bend	St. Joseph
Gruber, Charles M.	Indianapolis	Marion
Guckien, Joseph L.	Evansville	Vanderburgh
Guild, John K.	Plymouth	Marshall
Guin, Jere D.	Kokomo	Howard
Gumbert, Jack L.	Indianapolis	Marion
Gustafson, Milton H.	Muncie	Delaware-Blackford
Gustaitis, John W.	Whiting	Lake
Guthrie, James R.	Richmond	Wayne-Union
Guthrie, James U.	Peru	Miami
Guthrie, William H.	Butlerville	Jackson-Jennings
Gutierrez, Peter E.	Crown Point	Lake
Gutstein, Richard R. (S)	Kendallville	Noble
Guttman, John B.	Wakarusa	Elkhart
Guzman, Marcelino F.	Morocco	Newton

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Haas, Charles F.	Lafayette	Tippecanoe
Habegger, Elmer D.	Indianapolis	Marion
Hackett, Walter G.	Fort Wayne	Allen
Hade, Frederick L. (S)	Indianapolis	Marion
Hadey, James H.	Gary	Lake
Hadley, David	Indianapolis	Marion
Haffner, Herman G.	Fort Wayne	Allen
Hagan, Marion L.	French Lick	Orange
Haggard, David B.	Plainfield	Hendricks
Haggard, Edmund B.	Indianapolis	Marion
Hagie, Franklin E.	Richmond	Wayne-Union
Hagman, Norman A.	Ft. Leonard Wood, Mo.	Marion
Hales, Robert E.	Roachdale	Montgomery
Haley, Alvin J.	Fort Wayne	Allen
Haley, George M.	South Bend	St. Joseph
Haley, Paul E.	South Bend	St. Joseph
Halfast, Richard W.	Kokomo	Howard
Halikiopoulos, Harry J.	Gary	Lake
Hall, Bernard R.	Logansport	Cass
Hall, Donald L.	Petersburg	Pike
Hall, Frank M.	Indianapolis	Marion
Hall, Jack H.	Indianapolis	Marion
Hall, James M.	South Bend	St. Joseph
Hall, Robert S.	Muncie	Delaware-Blackford
Hall, Thomas C.	Chesterton	Porter
Hall, William R.	Fort Wayne	Allen
Halleck, Harold J.	Winamac	Pulaski
Haller, Richard C.	Fort Wayne	Allen
Haller, Robert L.	Kempton	Tipton
Haller, Thomas C.	Crawfordsville	Montgomery
Hamer, Homer G. (S)	Indianapolis	Marion
Hamilton, Antha A.	Vevay	Jefferson-Switzerland
Hamilton, Charles O.	South Bend	St. Joseph
Hamilton, Emory D.	Fort Wayne	Allen
Hamilton, George M.	Fort Wayne	Allen
Hamilton, Howard B.	Indianapolis	Marion
Hamilton, James R.	Mitchell	Lawrence
Hamilton, M. Luther (S)	Newberry	Greene
Hamilton, Orville G. (S)	Bluffton	Wells
Hamilton, Thomas	Columbia City	Whitley
Hammel, Howard T.	Bedford	Lawrence
Hammer, Jay W.	Indianapolis	Madison
Hammersley, George K.	Frankfort	Clinton
Hammond, R. Case	Evansville	Vanderburgh
Hammond, Stanley	Munster	Lake
Hampshire, Donald R.	Indianapolis	Marion
Hampton, James N.	Argos	Marshall
Han, Daniel	Gary	Lake
Hance, Darwood B.	Richmond	Wayne-Union
Hancock, John G.	Indianapolis	Marion
Haney, William K.	Madison	Jefferson-Switzerland
Hanley, Harriet F.	South Bend	St. Joseph
Hann, Eldon C.	Indianapolis	Marion
Hanna, Thomas A.	Indianapolis	Marion
Hannah, Jack W.	Elkhart	Elkhart
Hanneken, Vincent J.	Wabash	Wabash
Hannemann, Robert E.	Lafayette	Tippecanoe
Hansell, Robert M.	Indianapolis	Marion
Hanson, Martin F.	Elwood	Madison
Harcourt, Allan K.	Indianapolis	Marion
Harcourt, Robert S.	Indianapolis	Marion
Harden, Murray E.	Lafayette	Tippecanoe
Hardin, Wayne E.	Ossian	Wells
Harding, M. Richard	Indianapolis	Marion
Harding, Myron S.	Indianapolis	Marion
Hardtke, Eldred F.	Bloomington	Owen-Monroe
Hardy, John J. (S)	North Liberty	St. Joseph
Hare, Daniel M.	Evansville	Vanderburgh
Hare, Earl H. (S)	Indianapolis	Marion
Hare, Francis W., Jr.	Madison	Jefferson-Switzerland
Hare, Laura	Indianapolis	Marion
Harger, Robert W.	Indianapolis	Marion
Hargett, Herbert P.	Jeffersonville	Clark
Harkness, Robert G.	Terre Haute	Vigo
Harlan, William L.	Evansville	Vanderburgh
Harless, Clarence M.	Chesterton	Porter
Harless, O. Fred	Monroeville	Allen
Harmon, Carl J.	Richmond	Wayne-Union
Harned, Ben K.	Evansville	Vanderburgh
Harper, James W.	East Chicago	Lake
Harrington, James F.	Logansport	Cass
Harris, Carl B.	Indianapolis	Marion
Harris, George F.	Madison	Jefferson-Switzerland
Harris, Neil R.	Goshen	Elkhart
Harris, Paul N.	Greenfield	Marion
Harris, Robert F.	Noblesville	Hamilton
Harris, Robert L.	Evansville	Vanderburgh
Harris, Robert W.	New Albany	Floyd
Harrison, Benjamin L.	New Castle	Henry
Harshman, James A.	Kokomo	Howard
Harshman, Louis P. (S)	Fort Wayne	Allen
Harstad, Casper	Rockville	Parke-Vermillion
Hart, L. Paul	Evansville	Vanderburgh
Hart, Robert B.	Columbus	Bartholomew-Brown
Harter, Eli B.	Lafayette	Tippecanoe
Hartley, Clarence A., Jr.	Evansville	Vanderburgh
Hartman, John J.	Angola	Steuben
Hartsough, Ralph I.	Lakeville	St. Joseph
Hartz, F. Minton	Evansville	Vanderburgh
Harvey, Bennett B.	Lafayette	Tippecanoe
Harvey, Emerson C., Jr.	Muncie	Delaware-Blackford
Harvey, Harry C. (S)	Franklin	Allen
Harvey, John C.	Auburn	DeKalb
Harvey, Ralph J. (S)	Zionsville	Boone
Harvey, Verne K., Jr.	Indianapolis	Marion
Harvey, Verne K., Sr.	Zionsville	Marion
Hasewinkel, Carroll W.	Carmel	Marion
Hasewinkle, August M.	Fort Wayne	Allen
Hash, John S.	Noblesville	Hamilton
Hashemi, Hossein	Warsaw	Kosciusko
Haslem, Ezra R.	Terre Haute	Vigo
Haslem, John R.	Terre Haute	Vigo
Haslinger, Clarence J.	Indianapolis	Marion
Hassel, Walter B.	Evansville	Vanderburgh
Hastings, Warren C.	Fort Wayne	Allen
Hatfield, Jack J.	Indianapolis	Marion
Hatfield, Nicholas W.	Indianapolis	Marion
Hathaway, C. Bishop	Ft. Riley, Kansas	Marion
Hattendorf, Anton P.	Fort Wayne	Allen
Hauersperger, Alfred D.	Columbus	Bartholomew-Brown
Haugseth, Ellsworth K.	South Bend	St. Joseph
Hauss, Augustus P. (S)	New Albany	Floyd

Name	City	County
Havens, A. Lyle	Jeffersonville	Clark
Havens, Thomas R.	Jeffersonville	Clark
Havens, Oscar	Cicero	Hamilton
Havens, Russell E.	Fort Wayne	Allen
Hawes, Marvin E.	Columbus	Bartholomew-Brown
Hawk, James H.	Indianapolis	Marion
Hawkins, Glen E.	South Bend	St. Joseph
Hawkins, Richard D.	Bedford	Lawrence
Hay, Gene R.	Michigan City	La Porte
Hayes, Frank W.	San Francisco, Calif.	Lake
Hayes, Jesse D.	East Chicago	Lake
Hayes, Theodore R.	Muncie	Delaware-Blackford
Haymond, George M.	Warsaw	Kosciusko
Haymond, Joseph L.	Indianapolis	Marion
Haynes, John T.	Indianapolis	Marion
Hays, Everett L.	Indianapolis	Marion
Haywood, John G.	Noblesville	Hamilton
Headley, Lloyd M.	Lebanon	Boone
Healey, Robert J.	Indianapolis	Marion
Heard, Albert	Evansville	Vanderburgh
Heck, Martin C.	Jasper	Dubois
Hedde, Eugene L.	Logansport	Cass
Hedgcock, Robert A.	Frankfort	Clinton
Hedrick, James T.	Gary	Lake
Hedrick, Philip W.	Indianapolis	Marion
Hehemann, William V.	Munster	Lake
Heid, George J., Jr.	Lafayette	Tippecanoe
Heilman, William C., Jr.	New Castle	Henry
Heilman ,W. C., Sr. (S)	New Castle	Henry
Heimburger, Robert F.	Indianapolis	Marion
Heinlein, Carl L.	Danville	Hendricks
Heinrich, Weston A.	Evansville	Vanderburgh
Held, George A.	Jasper	Dubois
Heller, Nelson L. R. (S)	Dunkirk	Jay
Helmen, Charles H.	Indianapolis	Marion
Helmen, Harry W. (S)	Rolling Prairie	St. Joseph
Helmer, Frederic A.	Cincinnati, Ohio	Allen
Helmer, John F.	South Bend	St. Joseph
Heminway, Norman L.	Elkhart	Elkhart
Hendershot, Eugene L.	Evansville	Vanderburgh
Henderson, Francis G.	Indianapolis	Marion
Henderson, Norman C.	Michigan City	La Porte
Henderson, Ramon A.	Muncie	Delaware-Blackford
Henderson, Roscoe C.	Indianapolis	Marion
Henderson, William P.	Indianapolis	Marion
Hendricks, Fred A.	Indianapolis	Marion
Hendricks, John W.	Indianapolis	Marion
Hendrix, Charles E.	Vincennes	Knox
Henley, Glenn (S)	Fairmount	Grant
Henn, R. Anthony	Greenfield	Hancock
Henry, Alvin L.	Columbus	Bartholomew-Brown
Henry, Howard J.	Knox	Starke
Henry, Russell S.	Indianapolis	Marion
Hepburn, C. K.	Indianapolis	Marion
Hepner, Herman	Kendallville	Noble
Hepner, Herman S.	Bloomington	Owen-Monroe
Herd, Cloyn R.	Peru	Miami
Herendeen, Elbie V.	Rochester	Fulton
Heritier, C. Jules	Columbia City	Whitley
Hermayer, Stephen	Evansville	Vanderburgh
Hernandez, Antonio	Shelburn	Sullivan
Hernandez, I. C.	East Chicago	Lake
Herr, John W. (S)	Tell City	Perry
Herrick, Charles L.	Akron	Fulton
Herrmann, Gordon T.	Evansville	Vanderburgh
Herrold, George W.	Lafayette	Tippecanoe
Hershberger, Philip G.	Fort Wayne	Allen
Hershey, Ernest A. (S)	Churubusco	Whitley
Herzberg, Milton	Clinton	Parke-Vermillion
Herzer, Clarence C.	Evansville	Vanderburgh
Hess, Paul P.	New Albany	Floyd
Hetherington, John A.	Indianapolis	Marion
Hetman, Mitchell J.	Westville	La Porte
Heubi, John E.	Indianapolis	Marion
Hiatt, Russell L.	Venice, Fla.	Wayne-Union
Hibbs, William G.	Franklin	Johnson
Hibner, Dan W.	Indianapolis	Marion
Hibner, Nolan A.	Monticello	White
Hickam, John B.	Indianapolis	Marion
Hickman, Donald M.	Fort Wayne	Allen
Hickman, Jack W.	Indianapolis	Marion
Hickman, Walter F. (S)	Indianapolis	Marion
Hicks, Murwyn L.	Indianapolis	Marion
Hicks, Wilbur P.	Indianapolis	Marion
Hieber, Frank R.	Indianapolis	Marion
Higgins, James L.	Minot A.F.B., N. Dakota	Pike
Higgins, John R.	New Albany	Floyd
High, Ralph L.	Muncie	Delaware-Blackford
Hilbert, John W. (S)	South Bend	St. Joseph
Hildebrand, John O., Jr.	South Bend	St. Joseph
Hildebrand, William L.	Indianapolis	Marion
Hill, Gladys Marie	Richmond	Wayne-Union
Hill, Herbert N.	Indianapolis	Marion
Hill, James K.	Indianapolis	Marion
Hill, Kenneth G.	New Castle	Henry
Hill, Lloyd L.	Peru	Miami
Hill, Morris R.	Indianapolis	Marion
Hill, Paul G.	Cambridge City	Wayne-Union
Hill, Robert E.	Yorktown	Delaware-Blackford
Hill, Theodore A.	South Bend	St. Joseph
Hill, Wallace C.	South Bend	St. Joseph
Hillenbrand, Charles	Michigan City	La Porte
Hillery, John L.	Warsaw	Kosciusko
Hillery, Robert L.	Fort Wayne	Allen
Hillis, Lowell J.	Logansport	Cass
Hillman, Marion W.	Westville	St. Joseph
Himebaugh, Gilbert J.	Evansville	Vanderburgh
Himler, James M.	Indianapolis	Marion
Hinchman, Jean F.	Parker	Delaware-Blackford
Hines, Archie V. (S)	Auburn	De Kalb
Hines, Don C.	Indianapolis	Marion
Hines, John H.	Auburn	De Kalb
Hippensteel, Harland	Auburn	De Kalb
Hippensteel, Russell R.	Culver	Marshall
Hipskind, Richard E.	Fort Wayne	Allen
Hirsch, Herman L.	Mt. Vernon	Posey
Hisrich, Lloyd W.	Batesville	Ripley
Hobbs, Arthur A.	Evansville	Vanderburgh
Hobgood, James L., Jr.	Evansville	Vanderburgh
Hochhalter, Marian	Logansport	Cass
Hodges, Fletcher (S)	Indianapolis	Marion
Hodgin, Phillip T.	Orleans	Orange
Hodurski, Zigfield	Gary	Lake
Hoetzer, Eldore M.	New Haven	Allen
Hoffman, Arthur F.	Fort Wayne	Allen
Hoffman, Doris	Vincennes	Knox
Hoffman, Herman	Indianapolis	Marion
Hoffman, Max N.	Covington	Fountain-Warren
Hofmann, J. William (S)	Indianapolis	Marion
Hogan, Michael A.	Indianapolis	Marion
Hogan, Thomas W.	Terre Haute	Vigo
Hogle, Frank D.	Warsaw	Kosciusko
Hoham, Frederick D.	Portage	Lake
Hoit, Leonard	Gary	Lake
Holdeman, Lillian S.	South Bend	St. Joseph
Holdeman, Richard W.	South Bend	St. Joseph
Holladay, Lloyd J.	Lafayette	Tippecanoe
Holland, Deward J. (S)	Bloomington	Owen-Monroe
Holland, William M.	Indianapolis	Marion
Holland, Philip T.	Bloomington	Owen-Monroe
Hollenberg, Alfred E.	Hagerstown	Henry

Name	City	County
Hollenberg, Edward L.	Winamac	Pulaski
Holliday, Alfonso	Gary	Lake
Holman, Jerome E., Sr. (S)	Indianapolis	Marion
Holman, Jerome E., Jr.	Indianapolis	Marion
Holmes, Claude D. (S)	Coral Gables, Fla.	Clinton
Holmes, George H., Jr.	Indianapolis	Marion
Holmes, John L.	Muncie	Delaware-Blackford
Holsinger, Robert E.	Fort Wayne	Allen
Holtzman, Norman N.	South Bend	St. Joseph
Holtzman, Paul W.	Bloomington	Owen-Monroe
Honan, Paul R.	Lebanon	Boone
Hood, Ainslee A.	Indianapolis	Marion
Hooke, Samuel W. (S)	Noblesville	Hamilton
Hooker, Donald J.	Ligonier	Noble
Hoopes, Jane M.	Evansville	Vanderburgh
Hoover, Dewey A.	Terre Haute	Vigo
Hoover, J. Guy	Evansville	Vanderburgh
Hoover, Joseph R.	Fort Wayne	Allen
Hoover, Peter B.	Boonville	Warrick
Hopkins, Joseph R.	Hammond	Lake
Hoppenrath, William H. (S)	Elwood	Madison
Horlander, Fridolin	Henryville	Clark
Horning, Richard R.	Logansport	Cass
Horst, William N.	Crown Point	Lake
Horswell, Richard G.	Bristol	Elkhart
Horswell, Richard R.	Lafayette	Tippecanoe
Horwitz, Thomas	Indianapolis	Marion
Hostetler, Carl M.	Goshen	Elkhart
Hostetter, Irwin S.	Muncie	Delaware-Blackford
Houser, D. Stanley	South Bend	St. Joseph
Houser, Wayne W.	Monon	White
Houshmand, Cyrus	Bloomington	Owen-Monroe
Houston, Fred D.	Lawrenceburg	Dearborn-Ohio
Hovda, Richard B.	Evansville	Vanderburgh
Hover, Galen M.	Marion	Grant
How, Louis E.	South Bend	St. Joseph
Howard, Joseph D.	Culver	Marshall
Howard, Wm. Harry	Hammond	Lake
Howe, Fordyce L.	Fort Wayne	Allen
Howell, Arthur	Indianapolis	Marion
Howell, Joseph D.	Indianapolis	Marion
Hoyt, John M.	Kokomo	Howard
Hoyt, Lester H.	Indianapolis	Marion
Hoyt, Millard L.	Indianapolis	Marion
Hubbard, Jesse D.	Indianapolis	Marion
Huber, Carl P.	Indianapolis	Marion
Huckleberry, Irvin E.	Salem	Washington
Hudson, Arlington M.	Connersville	Fayette-Franklin
Hudson, Foster J.	Indianapolis	Marion
Huffman, Galen C.	Bluffton	Wells
Huffman, Verlin P.	S. Whitley	Whitley
Hughes, Richard R.	Lafayette	Tippecanoe
Huggins, Victor S.	Evansville	Vanderburgh
Hull, De Wayne L.	Indianapolis	Marion
Hull, James E.	Lafayette	Tippecanoe
Hull, Ronald H.	Indianapolis	Marion
Hummel, Russel M.	Marion	Grant
Hummons, Francis D.	Indianapolis	Marion
Humphrey, Edward M.	Covington	Fountain-Warren
Humphrey, Paul E.	Terre Haute	Vigo
Humphreys, Joe E.	Vincennes	Knox
Humphreys, John L.	Fort Wayne	Allen
Humphreys, John W.	Crawfordsville	Montgomery
Hunsberger, Walter G.	Lafayette	Tippecanoe
Hunt, Edgar J.	Terre Haute	Vigo
Hunt, Gayle J.	Richmond	Wayne-Union
Hunt, H. Richard	Indianapolis	Marion
Hunter, Donn R.	Greenfield	Hancock
Hunter, Frank P. (S)	Lafayette	Tippecanoe
Hunter, Lowell G.	Lawrenceburg	Dearborn-Ohio
Huoni, John S.	Jeffersonville	Clark
Hurley, James W.	Elkhart	Elkhart
Hurley, John R.	Daleville	Delaware-Blackford
Hurt, LaVerne B.	Delray Beach, Fla.	Marion
Hurteau, William W.	Indianapolis	Marion
Huse, William M.	Indianapolis	Marion
Husted, Robert G.	Hammond	Lake
Hutchison, Donald R.	Fountain City	Wayne-Union
Hutto, William H.	Kokomo	Howard
Hyatt, Gilbert T.	Evansville	Vanderburgh
Hyde, Carroll C.	South Bend	St. Joseph

I

Imhof, Joseph D.	Muncie	Delaware-Blackford
Ingram, Richard	Montpelier	Delaware-Blackford
Ingwell, Guy B.	Knox	Starke
Inlow, Herbert H.	Shelbyville	Shelby
Inlow, Paul M.	Shelbyville	Shelby
Inlow, Robert P.	Shelbyville	Shelby
Inlow, William D. (S)	Shelbyville	Shelby
Irish, Wilbur J.	East Chicago	Lake
Irmscher, George W.	Fort Wayne	Allen
Irmscher, Jane M.	Fort Wayne	Allen
Irvine, William O.	Indianapolis	Marion
Irwin, Glenn W., Jr.	Indianapolis	Marion
Isenogle, Kenneth F.	Fort Wayne	Allen
Iske, Paul G.	Indianapolis	Marion
Isler, Nathaniel C.	Jeffersonville	Clark
Iterman, George E.	New Castle	Henry
Ivy, John H.	Elkhart	Elkhart

J

Jackson, Charles E.	Bluffton	Wells
Jackson, Dean B.	Hartford City	Delaware-Blackford
Jackson, James W. (S)	Indianapolis	Marion
Jackson, John F.	Fort Wayne	Allen
Jackson, John K.	Aurora	Dearborn-Ohio
Jacobs, E. Robert	Columbus	Bartholomew-Brown
Jaeger, Alfred S. (S)	Indianapolis	Marion
Jahns, Albin A.	Gary	Lake
James, Charles E.	Indianapolis	Marion
James, John M.	Tell City	Perry
James, Nicholas A. (S)	Tell City	Perry
James, Thomas, Jr.	Huntington	Huntington
Jankowski, Ernest B.	South Bend	St. Joseph
Jaquith, Orville S. (S)	Indianapolis	Marion
Jarrett, John C.	Marion	Grant
Jarrett, Paul E.	Anderson	Madison
Jay, Arthur N.	Indianapolis	Marion
Jay, James M.	Indianapolis	Marion
Jehanyar, M. Ali	Monticello	White
Jenkins, Robert E.	Indianapolis	Marion
Jennings, Frank L. (S)	Indianapolis	Marion
Jett, Clyde W.	Seelyville	Vigo
Jewell, George M.	Kokomo	Howard
Jewett, Joe H.	Indianapolis	Marion
Jinnings, Loren E.	Garrett	De Kalb
Jobes, James E.	Indianapolis	Marion
Joffe, Herman	East Chicago	Lake
Johns, David R. (S)	East Chicago	Lake
Johns, Nicholas C.	South Bend	St. Joseph
Johnson, Arnold L.	Gary	Lake
Johnson, David G.	Anderson	Madison
Johnson, Earl H.	Indianapolis	Marion
Johnson, Edward M.	Terre Haute	Vigo
Johnson, George M.	Richmond	Wayne-Union
Johnson, Harold V.	Evansville	Vanderburgh
Johnson, Herbert S.	Lafayette	Tippecanoe

Name	City	County
Johnson, James B.	Greencastle	Putnam
Johnson, Jerome M.	Jeffersonville	Clark
Johnson, Lonnie B.	Gary	Lake
Johnson, Lowell R.	Lafayette	Tippecanoe
Johnson Paul D., Jr.	Terre Haute	Vigo
Johnson, Robert D.	Madison	Jefferson-Switzerland
Johnson, Stephen L.	Evansville	Vanderburgh
Johnson Thomas W.	Indianapolis	Marion
Johnson, William A.	North Vernon	Jackson-Jennings
Johnson, William H.	Gary	Lake
Johnston, Donald D.	Westville	La Porte
Johnston, Richard M.	Fort Wayne	Allen
Johnston, Robert G. (S)	Huntington	Huntington
Jolly, Lewis E.	Madison	Jefferson-Switzerland
Jolly, Wesley P. (S)	Richland	Spencer
Jones, Albert T.	Anderson	Madison
Jones, Allen W.	Indianapolis	Marion
Jones, Charles A.	Franklin	Johnson
Jones, David E.	Indianapolis	Marion
Jones, David H.	Charlestown	Clark
Jones, David M.	Lafayette	Tippecanoe
Jones, Edwin F.	Rensselaer	Jasper
Jones, Eli S.	Hammond	Lake
Jones, Francis P.	Indianapolis	Marion
Jones, George L.	Indianapolis	Marion
Jones, Gordon C.	Indianapolis	Marion
Jones, Harold N.	East Chicago	Lake
Jones, Horace E.	Anderson	Madison
Jones, J. Carl	Logansport	Cass
Jones, King S.	Michigan City	La Porte
Jones, Lawrence R.	Greencastle	Putnam
Jones, Robert B.	Elkhart	Elkhart
Jones, Roland W.	San Francisco, Calif.	Marion
Jontz, Joe G.	Fort Wayne	Allen
Jontz, Jon P.	Indianapolis	Marion
Jontz, Richard L.	Fort Wayne	Allen
Jordan, Leo E.	Lynn	Randolph
Jordan, Richard A.	Corydon	Harrison-Crawford
Joseph, Rex M.	Indianapolis	Marion
Jowitt, Richard H.	Indianapolis	Marion
Judd, Donald R.	Muncie	Delaware-Blackford
Judd, Russell L.	Indianapolis	Marion
Judson, Walter E.	Indianapolis	Marion
Juergens, Richard B.	Fort Wayne	Allen
Jurgensen, Walter T.	Fort Wayne	Allen
Justin, Renate G.	Terre Haute	Vigo

K

Kabel, Robert N.	Terre Haute	Vigo
Kahler, Maurice V.	Indianapolis	Marion
Kahn, Alexander J.	Indianapolis	Marion
Kahn, Howard L.	Indianapolis	Marion
Kaiser, James L.	Indianapolis	Marion
Kalb, Everett L.	Indianapolis	Marion
Kalker, Morton	Muncie	Delaware-Blackford
Kalsbeck, John E.	Indianapolis	Marion
Kaltenthaler, Albert	Gary	Lake
Kamen, Jack M.	Gary	Lake
Kamm, Bernard A.	South Bend	St. Joseph
Kammen, Leo	Indianapolis	Marion
Kammen, Robert	Oklahoma City, Okla.	Marion
Kammer, Grace C.	Muncie	Delaware-Blackford
Kammer, Walter F.	Muncie	Delaware-Blackford
Kantzer, Floyd B.	Garrett	De Kalb
Karberg, Richard J.	Lafayette	Tippecanoe
Karlick, Joseph R.	Arcadia	Hamilton
Karn, John W.	South Bend	St. Joseph
Karnafel, Eugene T.	Madison	Jefferson-Switzerland
Karol, Herbert J.	Fort Wayne	Allen
Karpel, Bernard	Mooresville	Hendricks
Karsell, William A.	Indianapolis	Marion
Kasting, Gerald	Bedford	Lawrence
Katterjohn, James C.	Indianapolis	Marion
Kauffman, Harley M.	Evansville	Vanderburgh
Kauffman, Nelson N.	Indianapolis	Marion
Kaufman, Julian R.	Fort Wayne	Allen
Kaufman, Lillie S.	Goshen	Elkhart
Kay, Oran E.	Spencer	Owen-Monroe
Keating, John U.	Elkhart	Elkhart
Kebel, Arthur P.	Indianapolis	Marion
Keck, Carleton A.	Fort Wayne	Allen
Keeling, Forrest E.	Portland	Jay
Keenan, George B.	Indianapolis	Marion
Keever, Charles H.	Indianapolis	Marion
Keiser, Venice D. (S)	Indianapolis	Marion
Kellar, Philip E.	Hobart	Lake
Kelly, Don E.	Indianapolis	Marion
Kelly, Frank (S)	Argos	Marshall
Kelly, John B.	Evansville	Vanderburgh
Kelly, Wendell C.	Anderson	Madison
Kelsey, Lawrence E.	Phoenix, Ariz.	Fulton
Kelsey, Robert M., Jr.	La Porte	La Porte
Kelsey, Robert M., Sr.	La Porte	La Porte
Kemker, Bernard P.	Tell City	Perry
Kemp, John T.	Michigan City	La Porte
Kemp, W. Alfred	Bourbon	Marshall
Kempf, Gerald F.	Rockville	Parke-Vermillion
Kendall, Forest M.	Nappanee	Elkhart
Kendall, William R.	Richmond	Wayne-Union
Kendrick, Frank J.	Gary	Lake
Kendrick, William M.	Mooresville	Morgan
Kennedy, Eva N. (S)	Camden	Carroll
Kennedy, Hunter F.	Indianapolis	Marion
Kennedy, Joseph T.	Indianapolis	Marion
Kennedy, Myron S.	Goshen	Elkhart
Kennedy, Walter U. (S)	New Castle	Henry
Kenney, David B.	Indianapolis	Marion
Kenney, Francis D.	Hammond	Lake
Kenoyer, Wilbur L.	New York, N. Y.	Marion
Kent, Richard N.	Fort Wayne	Allen
Kenyon, Charles E.	Cambridge City	Wayne-Union
Kenzler, Jack I.	Indianapolis	Marion
Keough, Thomas F.	Warsaw	Kosciusko
Kephart, S. Bruce	Bluffton	Wells
Kepler, Robert W.	La Porte	La Porte
Keplinger, James E.	Munster	Lake
Kepner, Robert S.	Chesterfield	Madison
Kercheval, John M.	Clinton	Parke-Vermillion
Kern, Clarence G.	Lebanon	Boone
Kerr, Charlotte H.	Michigan City	La Porte
Kerr, Donald M.	Bedford	Lawrence
Kerr, Harry R.	Indianapolis	Marion
Kerr, John E.	Michigan City	La Porte
Kerrigan, John F.	Michigan City	La Porte
Kerrigan, Robert L. (S)	Michigan City	La Porte
Kerrigan, William F.	Connersville	Fayette-Franklin
Keseric, N. E.	French Lick Springs	Orange
Kesim, Mufit H.	Elkhart	Elkhart
Kessler, Robert B.	Evansville	Vanderburgh
Ketcham, Jane M. (S)	Indianapolis	Marion
Ketcham, John S. (S)	Rossville	Clinton
Keyes, Robert C.	Fort Wayne	Allen
Khaton, Odessa M.	Gary	Lake
Kidd, James G. (S)	Jefferson, Wis.	Wabash
Kidder, Orva T.	Fort Wayne	Allen
Kiechle, Frederich L.	Evansville	Vanderburgh

Name	City	County
Kiely, John T.	Anderson	Madison
Kilgore, Byron W.	Ft. Wayne	Allen
Kilmer, Warren L.	Portage	Porter
Kim, Joon S.	Muncie	Delaware-Blackford
Kim, Young D.	Beech Grove	Marion
Kimbrough, Robert F.	Fort Wayne	Allen
Kime, Charles E.	Richmond	Wayne-Union
Kime, Edwin N. (S)	Bloomington	Marion
Kimmel, George E.	Evansville	Vanderburgh
Kincaid, Raymond K.	Tipton	Tipton
Kincaid, Robert S.	Evansville	Vanderburgh
Kindell, Hurschell D.	New Richmond	Montgomery
King, Harold	Indianapolis	Marion
King, Jay M.	Logansport	Cass
King, Joseph W.	Anderson	Madison
King, Robert W.	Cedar Lake	Lake
King, William E.	Indianapolis	Marion
Kingsbury, John K. (S)	Indianapolis	Marion
Kinneman, Robert E.	Greenfield	Hancock
Kintner, Burton E.	Elkhart	Elkhart
Kinzel, Robert J. W.	Indianapolis	Marion
Kirby, Ted C.	Greenfield	Hancock
Kirkhoff, Paul J.	Indianapolis	Marion
Kirklin, Oren L.	Indianapolis	Marion
Kirshman, Forrest E.	Muncie	Delaware-Blackford
Kirtley, James M.	Crawfordsville	Montgomery
Kirtley, Robert W.	Danville	Hendricks
Kirtley, William R.	Indianapolis	Marion
Kissel, Wesley A.	Indianapolis	Marion
Kissinger, Knight L.	Angola	Steuben
Kistler, James J.	La Porte	La Porte
Kistner, Arthur W.	Elkhart	Elkhart
Kitterman, Harry E.	Indianapolis	Marion
Klain, Benjamin V.	Indianapolis	Marion
Klamer, Charles H.	Jasper	Dubois
Klassen, Otto D.	Elkhart	Elkhart
Klatch, Ben Z.	Lafayette	Tippecanoe
Kleifgen, William A.	Fort Wayne	Allen
Klein, Emanuel	Bloomington	Owen-Monroe
Kleindorfer, Roscoe L.	Evansville	Vanderburgh
Kleopfer, Ronald G.	Fort Wayne	Allen
Klepfer, Jefferson F.	Richmond	Wayne-Union
Klepinger, Carol A.	Indianapolis	Marion
Klepinger, Harry E.	Lafayette	Tippecanoe
Klingerman, John J.	Kokomo	Howard
Klooze, Kenneth W.	Fort Wayne	Allen
Klutinoty, George II	Indianapolis	Marion
Kmak, Chester J.	Hammond	Lake
Knapp, Arthur L. (S)	South Bend	St. Joseph
Kneidel, John H.	Indianapolis	Marion
Knight, Lewis W.	Fort Wayne	Allen
Knockle, Wayne L.	Rochester	Fulton
Knode, Kenneth T.	South Bend	St. Joseph
Knotts, Halleck S.	Columbus	Bartholomew-Brown
Knotts, Slater	Columbus	Jackson-Jennings
Knowles, Charles Y.	Indianapolis	Marion
Knowles, Robert P.	Indianapolis	Marion
Ko, Richard C. B.	Gaston	Delaware-Blackford
Kobrin, Meyer W.	Gary	Lake
Koch, Edwin F., Jr.	Muncie	Delaware-Blackford
Koch, Elmer L.	Danville	Hendricks
Koch, Howard W.	Winchester	Randolph
Koehler, Elmer G.	Elkhart	Elkhart
Koenig, Robert L.	Valparaiso	Porter
Kohlstaedt, Karl C.	Indianapolis	Marion
Kohlstaedt, Kenneth G.	Indianapolis	Marion
Kohne, Gerald J.	Decatur	Adams
Kohne, Robert W.	Lafayette	Tippecanoe
Kolanko, Leon A.	Hammond	Lake
Kolettis, John G.	Gary	Lake
Komoroske, John E.	East Chicago	Lake
Kooiker, John E.	Indianapolis	Marion
Koons, Karl M. (S)	Indianapolis	Marion
Koontz, William A.	Gas City	Grant
Kopanko, Bernard F.	East Chicago	Lake
Kopcha, Joseph E.	Gary	Lake
Kopecky, Robert R.	Indianapolis	Marion
Kopp, William R.	Anderson	Madison
Koransky, David S.	Hammond	Lake
Korn, Jerome M.	Gary	Lake
Kornafel, L. H.	Indianapolis	Marion
Koss, K. William	Muncie	Delaware-Blackford
Kott, Alexander	Munster	Lake
Kourany, Edgar	Mooresville	Morgan
Kourany, Oscar	Mooresville	Morgan
Krabill, Willard S.	Goshen	Elkhart
Kraft, Bennett	Indianapolis	Marion
Kraft, Haldon	Noblesville	Hamilton
Kraning, Kenneth K.	Kewanna	Fulton
Krause, Friedrich	Elkhart	Elkhart
Kreitl, Dorothy R.	Richmond	Wayne-Union
Kremers, George A.	Kokomo	Howard
Kremp, Richard E.	Indianapolis	Marion
Kresler, Leon E.	Kentland	Newton
Kress, James W.	Muncie	Delaware-Blackford
Krieble, William W.	Terre Haute	Vigo
Kriel, William B.	Indianapolis	Marion
Krsek, Archie J.	Hobart	Lake
Krueger, John E.	Fort Wayne	Allen
Krueger, John E.	South Bend	St. Joseph
Krueger, Robert B.	Columbus	Bartholomew-Brown
Kruse, Walter E.	Fort Wayne	Allen
Kubik, Francis J.	Michigan City	La Porte
Kubley, James D.	Plymouth	Marshall
Kudele, Louis T.	Whiting	Lake
Kuhn, Arthur J.	Hammond	Lake
Kuhn, Frederick L.	South Bend	St. Joseph
Kuhn, Hedwig S.	Hammond	Lake
Kuhn, Robert W.	Wilkinson	Hancock
Kuipers, Fred M.	Lafayette	Tippecanoe
Kunkler, Arnold W.	Terre Haute	Vigo
Kunkler, Joseph (S)	Terre Haute	Vigo
Kunkler, William C. (S)	Terre Haute	Vigo
Kuntz, Herman W.	Indianapolis	Marion
Kurtz, Fred B. (S)	Indianapolis	Marion
Kurtz, Philip L.	Indianapolis	Marion
Kurtz, Richard	Ft. Riley, Kansas	Marion
Kurtz, William A.	Tipton	Tipton
Kwitny, Isadore J.	Indianapolis	Marion

L

LaBier, Clarence R., Jr.	Terre Haute	Vigo
LaBier, Clarence R. (S)	Terre Haute	Vigo
Lacy, John D., Jr.	Medaryville	Pulaski
Ladig, Donald S.	Fort Wayne	Allen
LaDine, Clarence B.	Indianapolis	Marion
LaDuron, Jules F. (S)	Muncie	Delaware-Blackford
LaFollette, Donald R.	New Albany	Floyd
LaFollette, Forrest R.	Hammond	Lake
LaFollette, Robert E.	New Albany	Floyd
Lahr, Richard E.	Marion	Grant
Laker, Gene C.	Fort Wayne	Allen
Laker, Richard J.	Fort Wayne	Allen
Lamb, Emmett B.	Indianapolis	Marion
Lamb, J. Leonard	South Bend	St. Joseph
Lamb, Russell W.	Indianapolis	Marion
Lamber, Chet K.	Indianapolis	Marion
Lamey, James L.	Anderson	Madison
Lamey, Paul T.	Anderson	Madison
Lamkin, E. Henry, Jr.	Indianapolis	Marion
Lampe, Elfred H.	Fort Wayne	Allen
Lancet, Robert O.	Terre Haute	Vigo

Name	City	County
Land, Francis L.	Fort Wayne	Allen
Land, Richard N.	Anderson	Madison
Landis, Charles B.	Lafayette	Tippecanoe
Lands, Robert M.	Portage	Porter
Landwehr, Alfons	Indianapolis	Marion
Lane, C. Elaine	Indianapolis	Marion
Lane, William H.	South Bend	St. Joseph
Lang, Erich K.	Indianapolis	Marion
Lang, Jay W.	Indianapolis	Marion
Langohr, John L.	Columbia City	Whitley
Langrall, Harrison M., Jr.	Marion	Grant
Lanman, John U.	Munster	Lake
Lanning, R. Adrian	Noblesville	Hamilton
Lansford, Kenneth G.	La Porte	La Porte
Largaespada, Manuel	Indianapolis	Marion
Larmore, Joseph L.	Anderson	Madison
Larrabee, James F.	Munster	Lake
Larzelere, Henry B.	Marion	Grant
Larson, Goyt O.	La Porte	La Porte
LaSalle, Richard M.	Wabash	Wabash
LaSalle, Robert M., Jr.	Wabash	Wabash
LaSalle, Robert M., Sr.	Wabash	Wabash
Lashmet, Michael H.	Indianapolis	Marion
Lasich, Anthony R.	Indianapolis	Marion
Laubscher, Clarence	Evansville	Vanderburgh
Laudeman, Walter A.	Elwood	Madison
Lauer, Dorothy B.	Dana	Parke-Vermillion
Lautz, Herbert A.	Hammond	Lake
Lavengood, Russell W.	Marion	Grant
Lawler, George F.	Cape Coral, Florida	Marion
Lawrance, Kingsley	Indianapolis	Marion
Lawrence, Joseph C.	Evansville	Vanderburgh
Lawson, Allan J.	Indianapolis	Marion
Lawson, Isaac H. (S)	Kendallville	Noble
Laycock, Richard M.	Fort Wayne	Allen
Lazo, Vicente R.	Gary	Lake
Leahy, Howard J.	Pendleton	Madison
Leak, Robert H.	Boswell	Benton
Leasure, J. Kent (S)	Indianapolis	Marion
Leatherman, Harter L.	Indianapolis	Marion
Lebioda, Henry S.	Gary	Lake
Lee, Glen Ward	Richmond	Wayne-Union
Lee, James	Terre Haute	Vigo
Lee, John M. (S)	Rushville	Rush
Lee, Robert Y.	Valparaiso	Porter
Leffel, James M.	Indianapolis	Marion
Leffler, William T.	Indianapolis	Marion
Lehman, David P.	Kokomo	Howard
Lehman, Emery W.	Bluffton	Wells
Lehman, Kenneth M.	Topeka	LaGrange
Lehmberg, Otto F. C.	Columbia City	Whitley
Leibundguth, Henry	Evansville	Vanderburgh
Leich, Charles F.	Evansville	Vanderburgh
Leinbach, Earl R.	Hamlet	Starke
LeMaster, Theodore R.	Indianapolis	Marion
Leming, Ben L.	Fort Wayne	Allen
Lenk, George G.	Fort Wayne	Allen
Lenox, Jack	Lebanon	Boone
Leroy, Alvin G.	Alexandria	Madison
Leser, Ralph U.	Indianapolis	Marion
Lessure, Alfred P.	Evansville	Vanderburgh
Lester, Vern L.	South Bend	St. Joseph
Lett, Emory B.	Loogootee	Daviess-Martin
Levatin, Bernard I.	South Bend	St. Joseph
Levi, Leon	Indianapolis	Marion
Levin, Eli L. (S)	East Chicago	Lake
Levin, Ralph T.	Indianapolis	Marion
Levkoff, Abner H.	South Bend	St. Joseph
Lewis, Earl T.	Evansville	Vanderburgh
Lewis, George N.	Gary	Lake
Lewis, James F.	Liberty	Wayne-Union
Lewis, Lucien A.	Gary	Lake
Lewis, Paul S.	Indianapolis	Marion
Lewis, R. Earl	Indianapolis	Marion
Lewis, Robert J.	Lawrence	Marion
Ley, Glen D.	Indianapolis	Marion
Libbert, Edwin L., Jr.	Madison	Jefferson-Switzerland
Lichtenberg, Melvin	Indianapolis	Marion
Liddell, Charles K.	Michigan City	La Porte
Lidikay, Edward C.	Indianapolis	Marion
Life, Homer L.	New Castle	Henry
Lindenborg, Paul G.	Indianapolis	Marion
Lindgren, Ivan T.	Lawrenceburg	Dearborn-Ohio
Lindsay, Hamlin B.	Washington	Daviess-Martin
Ling, John F.	Richmond	Wayne-Union
Lingeman, Byron N.	Crawfordsville	Montgomery
Lingeman, Raleigh E.	Indianapolis	Marion
Lingeman, Roger E.	Indianapolis	Marion
Link, Charles W., Jr.	Greenwood	Johnson
Link, Goethe (S)	Indianapolis	Marion
Link, William C.	Bloomington	Owen-Monroe
Lionberger, John R.	South Bend	St. Joseph
Lipschutz, Harold	Gary	Lake
Lipsey, Alfred J.	Gary	Lake
Liss, Emanuel C.	South Bend	St. Joseph
Little, John W. (S)	Mt. Zion, Ill.	Marion
Littlefield, Paul A.	Indianapolis	Marion
Littlefield, Shirley D.	Indianapolis	Marion
Litzenberger, Sam W.	Anderson	Madison
Llamas, Dominador F.	North Judson	Starke
Lloyd, Frank P.	Indianapolis	Marion
Lloyd, Joe R.	Noblesville	Hamilton
Lloyd, Robert P.	Fort Wayne	Allen
Lockhart, Jack M.	Connersville	Fayette-Franklin
Lockhart, Philip B.	South Bend	St. Joseph
Loehr, William M.	Indianapolis	Marion
Loewenstein, Werner L.	Terre Haute	Vigo
Logan, James Z.	Richmond	Wayne-Union
Logan, Richard S.	Fort Wayne	Allen
Lohman, Robert M.	Fort Wayne	Allen
Lohoff, Lewis C.	Tell City	Perry
Loh, Hwei Ya (Chang)	Gary	Lake
Loh, Wei-Ping	Gary	Lake
Long, Keith J.	Hammond	Lake
Long, Max R.	Marion	Grant
Long, Paul L.	Anderson	Madison
Longshore, Robert E.	Kokomo	Howard
Lonngren, Dudley H.	Marion	Grant
Loomis, Charles H.	Richmond	Wayne-Union
Loomis, Norman S.	Indianapolis	Marion
Loop, Frederick A.	Lafayette	Tippecanoe
Lord, Glen C.	Indianapolis	Marion
Lorenty, Thaddeus B.	Gary	Lake
Lorman, James G.	Fort Wayne	Allen
Louden, Robert W.	Indianapolis	Marion
Loudermilk, Jack L.	Fort Wayne	Allen
Loudermilk, Richard G.	Warsaw	Allen
Loughlin, L. Leo	Indianapolis	Marion
Love, George N.	Indianapolis	Marion
Love, V. Logan	Marion	Grant
Lovell, Martin H.	Gary	Lake
Lovett, Harvey D.	Whitestown	Boone
Loving, Jury B.	New Goshen	Vigo
Lozow, David	Indianapolis	Marion
Lucas, Clarence A., Jr.	Indianapolis	Marion
Luckett, Coen L. (S)	Terre Haute	Vigo
Ludwig, Paul E.	Crawfordsville	Montgomery
Luginbill, Howard M.	Berne	Adams
Lukemeyer, George T.	Indianapolis	Marion
Lukemeyer, St. John	Jasper	Dubois
Lundblad, Wilfred M.	Bloomington	Owen-Monroe
Lundeberg, Ralph A.	Griffith	Lake
Lundt, Milo O.	Elkhart	Elkhart
Lunsford, Thomas E.	Indianapolis	Marion
Lurie, Paul R.	Indianapolis	Marion
Luros, J. Theodore	Indianapolis	Marion
Lutes, David L. (S)	Edinburg	Johnson
Luther, William C.	Elkhart	Elkhart

Name	City	County
Lutz, Georgianna	Gary	Lake
Luzadder, John E.	New Carlisle	St. Joseph
Lybrook, Daniel E. (S)	Young America	Cass
Lybrook, William B.	Indianapolis	Marion
Lyman, Frank L.	Yonkers, N. Y.	Vanderburgh
Lynch, Harold D.	Evansville	Vanderburgh
Lynch, Otis R.	Marengo	Harrison-Crawford
Lynn, Gene E.	Indianapolis	Marion
Lyon, Florence M.	Portland	Jay
Lyon, William C.	Fort Wayne	Allen
Lyons, L. Mason	Terre Haute	Vigo
Lyons, Robert E.	Bloomington	Owen-Monroe
Lytwakiwsky, Anatol	Gary	Lake

M

MacDonell, Eldred H.	South Bend	St. Joseph
MacDougall, John D.	Indianapolis	Marion
MacKenzie, Pierce	Evansville	Vanderburgh
McAdams, Hugh B.	Lafayette	Tippecanoe
McAdams, Robert	Lafayette	Tippecanoe
McAfee, James R.	Lebanon	Boone
McAleese, George B.	Terre Haute	Vigo
McAlpine, Richard J.	Indianapolis	Marion
McAree, Francis E.	Indianapolis	Marion
McArt, Bruce A.	Elkhart	Elkhart
McAtee, Ott B.	Madison	Jefferson-Switzerland
McBride, James S. (S)	Indianapolis	Marion
McBride, Noel S.	Terre Haute	Vigo
McCalla, Charles X.	Paoli	Orange
McCallister, John W.	Fort Wayne	Allen
McCallister, Larry L.	Muncie	Delaware-Blackford
McCallum, Donald C.	Indianapolis	Marion
McCallum, Joseph T. C. (S)	Indianapolis	Marion
McCallum, Robert N.	Indianapolis	Marion
McCardle, Edward G.	Fort Wayne	Allen
McCarthy, Daniel F., Jr.	New York, N. Y.	Marion
McCartney, Donald H.	Indianapolis	Marion
McCarty, Virgil	Princeton	Gibson
McClain, Edwin S.	Indianapolis	Marion
McClain, Marvin L.	Scottsburg	Scott
McClary, Charles W.	Bloomington	Owen-Monroe
McClelland, Donald C. (S)	Lafayette	Tippecanoe
McClelland, Harry N.	New Castle	Henry
McClintock, James A.	Muncie	Delaware-Blackford
McClure, Clark	Knox	Starke
McClure, Glen	Sullivan	Sullivan
McClure, Morris E.	Union City	Randolph
McClure, Stanley E.	Monon	White
McClure, Warren N.	Kokomo	Howard
McConnaughey, Hal D.	Great Lakes, Ill.	Marion
McConnell, William C.	Sunman	Ripley
McCool, Joseph H.	Evansville	Vanderburgh
McCormack, Lloyd L.	Fremont	Steuben
McCormick, Charles O., Jr.	Indianapolis	Marion
McCormick, Hubert D. (S)	Vincennes	Knox
McCormick, Wilbur C.	Brazil	Clay
McCoy, Roy R.	Fort Wayne	Allen
McCraley, William J.	South Bend	St. Joseph
McCrea, Fred R.	Terre Haute	Vigo
McCullough, Henry G.	Columbus	Bartholomew-Brown
McCullough, James Y.	New Albany	Floyd
McDaniel, Franklin P. (S)	Atlanta	Hamilton
McDonald, Frank C.	New Castle	Henry
McDonald, Joseph D.	Evansville	Vanderburgh
McDonald, Ralph M.	South Bend	St. Joseph
McDonald, Virgil G. (S)	Anderson	Madison
McDonald, Walter E.	Gary	Lake
McDowell, Fletcher W.	Muncie	Delaware-Blackford
McDowell, George A.	Fort Wayne	Allen
McDowell, Mordecai M.	Vincennes	Knox
McEachern, Cecil G.	Fort Wayne	Allen
McElroy, James S.	New Castle	Henry
McElroy, Robert S.	Princeton	Gibson
McEwen, James W.	Terre Haute	Vigo
McFadden, James M.	Lafayette	Tippecanoe
McFarland, Corley B.	South Bend	St. Joseph
McGrath, Michael F.	Indianapolis	Marion
McGue, Frank J.	Michigan City	La Porte
McGuire, D. F. (S)	East Chicago	Lake
McIlroy, Richard J.	Richmond	Wayne-Union
McIlwain, Eleanor E.	Warren	Grant
McIlwain, Robert E.	Warren	Grant
McIndoo, Ralph E. (S)	Kokomo	Howard
McIntire, Clarence R.	Bloomington	Owen-Monroe
McIntosh, Wilbert	Riley	Vigo
McIntyre, Charles J. (S)	Indianapolis	Marion
McIntyre, James M.	Indianapolis	Marion
McKechnie, Robert K.	Jeffersonville	Clark
McKee, Harry G.	Rushville	Rush
McKee, Roy G.	New Castle	Henry
McKeeman, Donald H.	Fort Wayne	Allen
McKinley, A. David	Indianapolis	Marion
McKinley, Joseph	Lafayette	Tippecanoe
McKinley, Daniel H.	Lafayette	Tippecanoe
McKinney, Donald L.	Otterbein	Benton
McKittrick, Jack	Washington	Daviess-Martin
McLain, Clarence R., Jr.	Wright-Patterson AFB, Ohio	Marion
McLaren, Daniel E.	Indianapolis	Marion
McLaughlin, Gordon C.	Terre Haute	Vigo
McLaughlin, James R.	Flora	Carroll
McLean, James S.	Munster	Lake
McMahan, Virgil C.	Vincennes	Knox
McMeel, James	South Bend	St. Joseph
McMichael, Frank J. (S)	Hernando, Fla.	Lake
McNabb, George B. (S)	Carthage	Rush
McNabb, Richard C.	Carthage	Rush
McNaughton, Lawrence	Washington	Daviess-Martin
McNeely, Matthew J.	Dillsboro	Dearborn-Ohio
McPherson, Richard C.	Lafayette	Tippecanoe
McPherson, Thomas C.	Evansville	Vanderburgh
McQuiston, Ralph J.	Indianapolis	Marion
McTurnan, Robert W.	Indianapolis	Marion
McVey, Clarence A. (S)	Hammond	Lake
McWilliams, William B.	Liberty	Wayne-Union
Machledt, John H.	Whiteland	Johnson
Mackel, Frederick O.	Fort Wayne	Allen
Mackey, Colonel G. (S)	Logansport	Cass
Mackey, Harry S. (S)	Indianapolis	Marion
Mackey, John E.	Indianapolis	Marion
Macri, Paul A.	Mishawaka	St. Joseph
Macy, George W.	Columbus	Bartholomew-Brown
Madlang, Rodolfo M.	Munster	Lake
Madden, Robert J.	Indianapolis	Marion
Mader, John H.	Richmond	Wayne-Union
Madtson, A. Ricks	Indianapolis	Marion
Magennis, Herbert L. (S)	Indianapolis	Marion
Mahank, Camiel C.	Mishawaka	St. Joseph
Mahoney, Charles L.	Terre Haute	Vigo
Majsterek, Stanley L.	Gary	Lake
Makovsky, Theodore	Valparaiso	Porter
Malcolm, Russell L., Jr.	Indianapolis	Marion

Name	City	County
Malcolm, Russell L.	Richmond	Wayne-Union
Malone, Leander A.	Terre Haute	Vigo
Malott, Fred R.	Converse	Miami
Malouf, Stephen D. (S)	Peru	Miami
Malstaff, Comiel M.	Mishawaka	St. Joseph
Manalan, Maurice M.	Indianapolis	Marion
Manalo, Francisco S.	Gary	Lake
Manders, Karl L.	Indianapolis	Marion
Manhart, Doyle B.	Sheridan	Hamilton
Manifold, Harold M.	Bloomington	Owen-Monroe
Manion, Marlow W.	Indianapolis	Marion
Mankin, William J.	Terre Haute	Vigo
Mann, Mortimer	Indianapolis	Marion
Mann, Richard E.	Fort Wayne	Allen
Manner, Richard J.	Evansville	Vanderburgh
Manning, George C.	Fort Wayne	Allen
Manning, K. Randolph	Indianapolis	Marion
Mannion, Rodney A.	Michigan City	La Porte
Manship, C. Stanley	Paoli	Orange
Mansueto, Mario D.	Hammond	Lake
Manzie, Michael W.	Indianapolis	Marion
Maple, James B. (S)	Sullivan	Sullivan
Marchand, Edwin V.	Haubstadt	Gibson
Marchant, Clarence H.	Bloomington	Owen-Monroe
Marcus, Emanuel	Hammond	Lake
Marcus, Morris C. (S)	Gary	Lake
Maris, Lee J.	Attica	Fountain-Warren
Mark, George A.	Elkhart	Elkhart
Markle, Joseph G.	Hobart	Lake
Marks, Howard H.	Huntington	Huntington
Marks, Maurice I.	Indianapolis	Marion
Marks, Ora L.	East Chicago	Lake
Marks, Salvo P.	Hammond	Lake
Markstone, David H.	Indianapolis	Marion
Maroc, James A.	Hammond	Lake
Marquinez, Adoracion	East Chicago	Lake
Marquis, Gordon	South Bend	St. Joseph
Marr, Griffith	Columbus	Bartholomew-Brown
Marsh, Carl M.	Indianapolis	Marion
Marsh, George W.	Lafayette	Tippecanoe
Marsh, Myrle F.	Fort Wayne	Allen
Marshall, Albert L., Jr.	Indianapolis	Marion
Marshall, Caesar L.	Fort Wayne	Allen
Marshall, Cavins R. (S)	Indianapolis	Marion
Marshall, George L. (S)	Bourbon	Marshall
Marshall, Millard R.	Gary	Lake
Marshall, Thos. J. (S)	Charlestown	Clark
Marshall W. J., Jr.	Hammond	Lake
Marske, Robert L.	Michigan City	La Porte
Martin, Charles E. (S)	Lynn	Randolph
Martin, Charles F., Jr.	Minneapolis, Minn.	St. Joseph
Martin, Floyd S.	Goshen	Elkhart
Martin, Guy	Seymour	Jackson-Jennings
Martin, Hugh E.	Indianapolis	Marion
Martin, Joe M.	Lafayette	Tippecanoe
Martin, Loren H.	Indianapolis	Marion
Martin, Paul H.	Elkhart	Elkhart
Martin, Samuel W.	Corydon	Harrison-Crawford
Martinov, William E.	South Bend	St. Joseph
Martirez, N. A.	Schererville	Lake
Martz, Bill L.	Indianapolis	Marion
Martz, Carl D.	Indianapolis	Marion
Marvel, Howard R.	Lafayette	Tippecanoe
Marvel, James A.	Evansville	Vanderburgh
Marvel, Robert J.	Indianapolis	Marion
Maschmeyer, Robert H.	Logansport	Cass
Mason, Bernard A.	South Bend	St. Joseph
Mason, Donald G.	Angola	Steuben
Mason, Everett E.	Evansville	Vanderburgh
Mason, John C.	Munster	Lake
Mason, Lester M.	Terre Haute	Vigo
Mason, Richard L.	Hammond	Lake
Massanari, Walter S.	Millersburg	Elkhart
Masters, John M.	Indianapolis	Marion
Masters, Robert J.	Indianapolis	Marion
Mastrangelo, M. J.	Fort Wayne	Allen
Mather, Charles R.	Lafayette	Tippecanoe
Mather, J. Winford	East Gary	Lake
Mather, Robert L.	Lafayette	Tippecanoe
Matheu, Heracleo	Logansport	Cass
Mathews, James R.	Evansville	Vanderburgh
Mathewson, Russell C.	Muncie	Delaware-Blackford
Mathys, Alfred (S)	Louisville, Ky.	Harrison-Crawford
Matter, Milton, Jr.	In Air Force	Grant
Matthew, John R.	Westville	La Porte
Matthew, W. Burleigh	Indianapolis	Marion
Matthews, Bernard J.	Indianapolis	Marion
Matthews, William M.	Indianapolis	Marion
Mattox, Don M.	Terre Haute	Vigo
Matzen, Richard N.	Bluffton	Wells
Maurer, J. Frank	Brazil	Clay
Maurer, Robert M.	Brazil	Clay
Mauricio, Amado S. A.	Rising Sun	Dearborn-Ohio
Mauzy, Merritt C.	South Bend	St. Joseph
Maxam, B. T.	Indianapolis	Marion
Maxson, Roy V.	Evansville	Vanderburgh
May, Richard M.	Gary	Lake
May, William D.	Rockville	Parke-Vermillion
Mayberry, Alton R.	Chapel Hill, N. C.	Vanderburgh
Mayfield, Clifford H. (S)	Reynolds	White
Mayock, Peter P.	Bluffton	Wells
Mayorga, Alfredo	Gary	Lake
Mead, Clarence H. (S)	Bluffton	Wells
Mead, Frank E.	La Porte	La Porte
Mealey, John, Jr.	Indianapolis	Marion
Medcalf, Norman L. (S)	Lamar	Spencer
Megenhardt, Dennis S.	Indianapolis	Marion
Mehne, Richard G.	Brazil	Clay
Meier, Donald W.	Bluffton	Wells
Meikle, Louise J. (S)	W. Lafayette	Tippecanoe
Meiks, Lyman T.	Indianapolis	Marion
Meiser, Robert D.	Huntington	Huntington
Meissel, Robert L.	Terre Haute	Vigo
Meister, Doris (S)	Anderson	Madison
Melin, John R.	Indianapolis	Marion
Mendelson, Stanley M.	Kokomo	Howard
Mendez, Carlos	Westville	Elkhart
Mensch, James R.	Fort Wayne	Allen
Mentendiek, Maurice H.	Indianapolis	Marion
Mercer, Samuel R.	Fort Wayne	Allen
Meredith, Elwood J.	Richmond	Wayne-Union
Mericle, Earl W.	Indianapolis	Marion
Merritt, A. Donald	Indianapolis	Marion
Merritt, Doris H.	Indianapolis	Marion
Mershon, Jack B.	Indianapolis	Marion
Mertz, Henry O. (S)	Nokomis, Fla.	Marion
Mertz, John H. O.	Indianapolis	Marion
Messer, Frank W.	Kendallville	Noble
Metcalfe, Grant E.	South Bend	St. Joseph
Meyer, Hans	Westville	La Porte
Meyer, Herman A.	Fort Wayne	Allen
Meyer, Theodore O.	Fort Wayne	Allen
Meyn, Werner P.	Terre Haute	Vigo
Michael, Isaac E.	Indianapolis	Marion
Michael, Robert L.	Kokomo	Howard
Michaelis, Stephen C.	Fort Wayne	Allen
Middleton, Harvey N.	Indianapolis	Marion
Middleton, Ramona J.	Elkhart	Elkhart
Middleton, Thomas O.	Bloomington	Owen-Monroe
Miklozek, John E.	Terre Haute	Vigo
Milan, Joseph F.	Bloomington	Owen-Monroe
Milan, Shijachki D.	East Chicago	Lake
Millan, Felix	Indianapolis	Marion
Miller, Albert J.	Lafayette	Tippecanoe
Miller, Charles L.	Vincennes	Knox
Miller, Dan T. (S)	Fowler	Benton

Name	City	County
Miller, Don E.	Fort Wayne	Allen
Miller, Donald C.	Cedar Lake	Lake
Miller, Donald G.	Elkhart	Elkhart
Miller, Edward D.	Fort Wayne	Allen
Miller, Frank H.	Indianapolis	Marion
Miller, Galen R.	Elkhart	Elkhart
Miller, H. Allison	Marion	Grant
Miller, H. Paul	Fort Wayne	Allen
Miller, Harold E.	Seymour	Jackson-Jennings
Miller, Harold L.	Richmond	Wayne-Union
Miller, Hugh A.	Elkhart	Elkhart
Miller, James	Wakarusa	Elkhart
Miller, James C.	Greensburg	Decatur
Miller, Jerry A.	Indianapolis	Marion
Miller, Jerry R.	Indianapolis	Marion
Miller, John D.	Indianapolis	Marion
Miller, John M.	Bloomington	Owen-Monroe
Miller, Joseph A.	Oaklandon	Hancock
Miller, Kenneth D.	Woodburn	Allen
Miller, LaVerne B.	Evansville	Vanderburgh
Miller, Mahlon F.	Fort Wayne	Allen
Miller, Maurice	Michigan City	La Porte
Miller, Milton J.	Evansville	Vanderburgh
Miller, Milo K. (S)	South Bend	St. Joseph
Miller, Orval J.	Fort Wayne	Allen
Miller, Ray D.	Martinsville	Morgan
Miller, Richard C.	Shelbyville	Shelby
Miller, Richard H.	Fort Wayne	Allen
Miller, Robert B.	Fort Wayne	Allen
Miller, Robert J.	Paragon	Morgan
Miller, Roland E.	Lafayette	Tippecanoe
Miller, Roscoe E.	Indianapolis	Marion
Miller, Samuel T. (S)	Elkhart	Elkhart
Miller, Virgil C.	Akron	Fulton
Miller, Wayne S.	Flint, Mich.	Huntington
Miller, William A.	Hagerstown	Henry
Miller, William J.	Fort Wayne	Allen
Milleson, Ann L. M.	Terre Haute	Vigo
Millis, Arthur B.	Richmond	Wayne-Union
Millis, Samuel C.	Crawfordsville	Montgomery
Mills, Fred E.	Evansville	Vanderburgh
Mills, John F.	Wabash	Wabash
Milne, Walter S.	Michigan City	La Porte
Milos, Robert J.	Gary	Lake
Milroy, Robert A.	Bluffton	Wells
Minczewski, Richard C.	Gary	Lake
Minich, William G.	Newport	Parke-Vermillion
Minick, Linus J.	Churubusco	Whitley
Mininger, Edward P.	Elkhart	Elkhart
Mino, Robert A.	Evansville	Vanderburgh
Mintz, Alfred M.	Munster	Lake
Mirro, John A.	Lowell	Lake
Misch, William	Cedar Lake	Lake
Mishkin, Irving	Elkhart	Elkhart
Mishler, Joe B.	Pierceton	Whitley
Mitchell, John R.	Terre Haute	Vigo
Mitchell, George H.	Indianapolis	Marion
Mitchell, George L. (S)	Smithville	Owen-Monroe
Mitchell, Georgia B.	Gary	Lake
Mitman, Floyd B.	Huntington	Huntington
Mladick, Edward A.	Michigan City	La Porte
Moak, Glenn D.	Indianapolis	Marion
Moats, Carl F.	Fort Wayne	Allen
Moats, George E. (S)	Fort Wayne	Allen
Mock, Harry E., Jr.	Franklin	Johnson
Modisett, Jackson W.	Madison	Jefferson-Switzerland
Modisett, Marcella S.	Madison	Jefferson-Switzerland
Modjeski, Joseph R.	Hammond	Lake
Moeller, Victor C.	Fort Wayne	Allen
Moenning, John E.	Indianapolis	Marion
Moheban, Joseph	Shelbyville	Shelby
Mohler, Floyd W.	Columbus	Bartholomew-Brown
Molengraft, Cornelius J.	Gary	Lake
Moleski, Walter L.	Griffith	Lake
Monar, Michael	Rockport	Spencer
Moneyhun, James E.	Anderson	Madison
Monroe, F. Bruce	Crown Point	Lake
Montes, Herminio Y.	Hammond	Lake
Montgomery, Lall G.	Muncie	Delaware-Blackford
Montgomery, Ralph F.	Muncie	Marion
Montgomery, Samuel B. (S)	Cynthiana	Posey
Montgomery, William F.	Indianapolis	Marion
Moon, Charles E.	Center Point	Clay
Moore, Donald F.	Indianapolis	Marion
Moore, Edwin G.	Gary	Lake
Moore, Harold T.	Indianapolis	Marion
Moore, Jack C.	Muncie	Delaware-Blackford
Moore, Martha	Hanover	Jefferson-Switzerland
Moore, Richard B.	St. Paul, Minn.	Marion
Moore, Robert G.	Vincennes	Knox
Moore, Thomas C.	Muncie	Delaware-Blackford
Moore, William C. (S)	Muncie	Delaware-Blackford
Moore, William G.	La Porte	La Porte
Moosey, Louis	Union Mills	La Porte
Moran, William J.	Indianapolis	Marion
Moravec, Arthur E.	Fort Wayne	Allen
Morchan, Samuel	Indianapolis	Marion
Morey, Edwin E.	Fort Wayne	Allen
Morgan, Margaret E.	Indianapolis	Marion
Morgan, Milton M.	Fort Wayne	Allen
Morgan, Peter P.	Richmond	Wayne-Union
Moriarty, John R.	Indianapolis	Marion
Morrical, Russell J.	Logansport	Cass
Morris, Hyman R.	Gary	Lake
Morris, Jean W.	Muncie	Delaware-Blackford
Morris, Robert A.	Anderson	Madison
Morris, Warren V.	Monticello	White
Morrison, George G.	Portland	Jay
Morrison, George G., Jr.	Lawrenceburg	Dearborn-Ohio
Morrison, James T.	Greensburg	Decatur
Morrison, Lewis E.	Indianapolis	Marion
Morrison, William R. (S)	Kokomo	Howard
Morrow, Dean H.	Bethesda, Md.	Marion
Morrow, Robert J.	Bedford	Lawrence
Morse, Arthur S.	E. Riverdale, Maryland	Delaware-Blackford
Mortenson, Leland J.	Fort Wayne	Allen
Morton, David P.	Westville	La Porte
Morton, Joseph L.	Indianapolis	Marion
Morton, Walter P.	Indianapolis	Marion
Moser, Elmer B. (S)	Windfall	Tipton
Moser, Rollin H.	Indianapolis	Marion
Moses, George E.	Worthington	Greene
Moses, Robert E.	Worthington	Greene
Moss, Bobby L.	Indianapolis	Marion
Moss, Harlan B.	Indianapolis	Marion
Moss, Herschel C.	Indianapolis	Marion
Moss, Mavor J.	Yorktown	Delaware-Blackford
Moswin, Jack A.	Gary	Lake
Mothersill, Mark H. (S)	Indianapolis	Marion
Mott, Cassell A.	South Bend	St. Joseph
Mott, William H.	Gary	Lake
Moulton, Lillian G.	Evansville	Vanderburgh
Mount, Mathias S.	Bloomfield	Greene
Mount, William M.	Lafayette	Tippecanoe
Mountain, Francis B.	Connersville	Fayette-Franklin
Mouser, Robert W.	Indianapolis	Marion
Mudd, Joseph P.	Clarksville	Clark
Muelchi, Adeline F.	Evansville	Vanderburgh
Mullen, James B.	Indianapolis	Marion

Name	City	County
Mueller, Edwin C.	La Porte	La Porte
Mueller, Hilbert M.	South Bend	St. Joseph
Mueller, Lawrence W.	Fort Wayne	Allen
Muhleman, Charles E.	La Porte	La Porte
Muller, Lullus P.	Indianapolis	Marion
Muller, Paul F.	Indianapolis	Marion
Muller, Victor H.	Indianapolis	Marion
Mullican, William S.	Indianapolis	Marion
Murdock, Harvey L. (S)	Fort Wayne	Allen
Murphy, Edward U.	Evansville	Vanderburgh
Murphy, Eugene C.	South Bend	St. Joseph
Murphy, Joseph F.	Lansing, Ill.	Lake
Murphy, Josephine F.	South Bend	St. Joseph
Murray, Ernest C.	Kokomo	Howard
Murray, James S.	Camarillo, Calif.	Marion
Murray, William E.	New Castle	Henry
Musselman, Glen G.	Terre Haute	Vigo
Musser, A. Wendell	Durham, N. C.	Marion
Myers, Charles W. (S)	Indianapolis	Marion
Myers, Philip R.	South Bend	St. Joseph
Myers, Roy V. (S)	West Palm Beach, Fla.	Marion

N

Nagan, Robert F.	Indianapolis	Marion
Nash, Justin R.	Albion	Noble
Nason, Robert A.	Garrett	De Kalb
Navin, Hugh K.	Fortville	Hancock
Navarre, Vincent J.	Munster	Lake
Nay, Ernest O. (S)	Terre Haute	Vigo
Nay, Richard M.	Indianapolis	Marion
Neal, Leonard W.	Hammond	Lake
Neale, Alfred E.	Anderson	Madison
Nedelkoff, Bogdan	New Albany	Floyd
Neece, Gus W.	Muncie	Delaware-Blackford
Need, David J.	Indianapolis	Marion
Need, Louis T.	Indianapolis	Marion
Need, Richard L.	Agana, Guam	Marion
Neher, John L.	South Bend	St. Joseph
Neidballa, Edward G.	Bristol	Elkhart
Neifert, Noel L.	Tell City	Perry
Nelson, Carl A.	West Lebanon	Fountain-Warren
Nelson, F. Dale	South Bend	St. Joseph
Nelson, Harold E.	Muncie	Delaware-Blackford
Nelson, John W.	Memphis, Tenn.	Marion
Nelson, Raymond E.	South Bend	St. Joseph
Nelson, Walfred A.	Gary	Lake
Nenneker, Henry (S)	Evansville	Vanderburgh
Nesbit, Leonard L.	Anderson	Madison
Nester, Henry G.	Indianapolis	Marion
Neudorff, Louis G.	Terre Haute	Vigo
Neukamp, Frank H.	Connersville	Fayette-Franklin
Neumann, Kenneth O.	Lafayette	Tippecanoe
Newby, Eugene	Sheridan	Hamilton
Newcomb, William K.	Royal Center	Cass
Newman, Alvin E.	Ft. Lauderdale, Fla.	Vanderburgh
Newman, Daniel M.	Vandenburg, Calif.	Marion
Newnum, Raymond L.	Evansville	Vanderburgh
Newsome, C. K.	Evansville	Vanderburgh
Niccum, Warren L.	Columbia City	Whitley
Nicholas, Dennis J.	Indianapolis	Marion
Nichols, Anne Sackett	Greencastle	Putnam
Nichols, Robert J.	Vincennes	Knox
Nicholson, Raymond W.	Evansville	Vanderburgh
Nicosia, John B.	East Chicago	Lake
Nie, Louis W.	Indianapolis	Marion
Niedermayer, Alfred J.	Evansville	Vanderburgh
Nigh, Rufus M.	Fairland	Shelby
Nill, John H.	Fort Wayne	Allen
Nixon, Byron	Farmland	Randolph
Noblitt, James S. (S)	Rockville	Parke-Vermillion
Nodinger, Louis	Hammond	Lake
Noe, William R.	Bedford	Lawrence
Nohl, John M.	Indianapolis	Marion
Nolan, Gerald R.	Fort Wayne	Allen
Nolin, Richard T.	Indianapolis	Marion
Nolt, Ernest V. (S)	Columbia City	Whitley
Nolting, Henry F. (S)	Indianapolis	Marion
Nonte, Leo R.	Evansville	Vanderburgh
Noonan, Leo C.	Portage	Porter
Norman, William H.	Indianapolis	Marion
Norris, Allen A. (S)	Elkhart	Elkhart
Norris, Marvin G.	Rushville	Rush
Norris, Max S.	Indianapolis	Marion
Norton, Harold J.	Columbus	Bartholomew-Brown
Norton, Horace O.	Washington	Daviess-Martin
Nourse, Myron H.	Indianapolis	Marion
Noveroske, Richard J.	Evansville	Vanderburgh
Novy, Charles A.	Garrett	De Kalb
Nugen, Harold	Auburn	De Kalb
Nugent, Edwin J.	Indianapolis	Marion
Nurnberger, John I.	Indianapolis	Marion
Nutter, Wyndham H.	Rushville	Rush

O

Oak, David D., Sr. (S)	LaCrosse	La Porte
Oak, David D., Jr.	Hanna	La Porte
Oatman, Jack G.	Fort Wayne	Allen
Oberlander, Seymour	Gary	Lake
O'Brian, Earl J.	Indianapolis	Marion
O'Brian, John F.	Fort Wayne	Allen
O'Brien, Francis E.	Rensselaer	Jasper
O'Brien, Raymond J.	Michigan City	La Porte
O'Bryan, Richard B.	Columbus	Bartholomew-Brown
Oca, Clemente F.	Jeffersonville	Clark
Ochsner, Harold C.	Indianapolis	Marion
Ochsner, Harold C., Jr.	Bellevue, Nebr.	Marion
Ockerman, Kenneth R.	Rensselaer	Jasper
Offutt, Andrew C.	Indianapolis	Marion
Ogle, Robert W.	Greenwood	Johnson
Olcott, Charles W.	Aurora	Dearborn-Ohio
Oldag, George E.	Elwood	Madison
Oliphant, Frank W.	Mount Vernon	Posey
Olivo, Marciano T.	Gary	Lake
Olson, Donald T.	South Bend	St. Joseph
Olson, Kenneth L.	South Bend	St. Joseph
Olson, Leslie D.	Gary	Lake
Olson, William H.	Michigan City	La Porte
Olvey, Ottis N.	Indianapolis	Marion
Omstead, Milton	Petersburg	Pike
Omstead, Trevalyn W.	Huntington	Huntington
O'Neill, Martin J.	Valparaiso	Porter
Onorato, Joseph J.	Lafayette	Tippecanoe
Onyett, Harold R.	Greenwood	Marion
Orders, Clarke E. (S)	Indianapolis	Marion
Oren, William F.	South Bend	St. Joseph
Ornelas, Joseph P.	Gary	Lake
O'Rourke, Carroll	Fort Wayne	Allen
Orr, W. Robert	Mishawaka	St. Joseph
Osborne, John V.	Muncie	Delaware-Blackford
Oster, Jack H.	Westville	La Porte
Osterman, Louis H.	Seymour	Jackson-Jennings
Ostheimer, George	Martinsville	Morgan
Oswald, Robert H.	Evansville	Vanderburgh
Oswalt, James T.	Mitchell	Lawrence

Name	City	County
Otten, Claude F.	Indianapolis	Marion
Otten, Ralph E.	Darlington	Montgomery
Overley, Ross A.	Indianapolis	Marion
Overley, Toner M., Jr.	Indianapolis	Marion
Overpeck, Charles	Greensburg	Decatur
Overpeck, George H.	Alexandria	Madison
Overshiner, Lyman (S)	Columbus	Bartholomew-Brown
Owen, John E.	Indianapolis	Marion
Owen, Margaret T.	Bloomington	Owen-Monroe
Owen, Thomas F.	Alexandria	Madison
Owens, Tracy C.	Indianapolis	Marion
Owsley, Guy A.	Hartford City	Delaware-Blackford
Oyer, John H.	Huntsville, Texas	Allen
Ozalan, Necmettin H.	St. Meinrad	Dubois

P

Pace, Jerome V.	Indianapolis	Parke-Vermillion
Paff, William A.	Elkhart	Elkhart
Paine, George E.	Elkhart	Elkhart
Painter, Donald S.	Fort Wayne	Allen
Painter, Lowell W.	Winchester	Randolph
Pairitz, Frank D.	South Bend	St. Joseph
Palmer, Barron M. F.	Hammond	Lake
Palmer, Charman F.	Indianapolis	Marion
Palmer, Harley P.	Indianapolis	Marion
Palmer, Robert M.	Indianapolis	Marion
Palmer, Robert W.	Indianapolis	Marion
Panares, Solomon V.	Hammond	Lake
Pancost, Vernon K.	Elkhart	Elkhart
Panos, Constantine O.	Bluffton	Wells
Pantzer, John G., Jr.	Indianapolis	Marion
Pappas, Eddie T.	Gary	Lake
Paras, Jose L.	Batesville	Ripley
Paris, Durward W.	Kokomo	Howard
Paris, John M.	New Albany	Floyd
Park, Byron J.	Richmond	Wayne-Union
Parker, Carey B.	Fort Wayne	Allen
Parker, Carl B.	Wingate	Montgomery
Parker, E. Camille	Logansport	Cass
Parker, Francis W., Jr.	Logansport	Cass
Parker, George F., Jr.	Indianapolis	Marion
Parker, Harry C. (S)	Hobart	Lake
Parker, John B.	Versailles	Ripley
Parker, John C.	Goodland	Newton
Parker, John F.	Indianapolis	Marion
Parker, Portia	Indianapolis	Marion
Parks, George O.	Hartford City	Delaware-Blackford
Parks, Herbert E.	Houston, Texas	Marion
Parmenter, Harry B.	Vincennes	Knox
Parr, Robert L.	Indianapolis	Marion
Parratt, Louis W.	Gary	Lake
Parrish, Richard K.	Decatur	Adams
Parrot, Donald J.	Fort Wayne	Allen
Parshall, Dale B.	Elkhart	Elkhart
Parsons, Robert L.	South Bend	St. Joseph
Pascuzzi, Chris A.	South Bend	St. Joseph
Paskind, Jacob	Indianapolis	Marion
Pastor, Julius W.	Evansville	Vanderburgh
Patterson, Jack W.	Fort Wayne	Allen
Patterson, William K.	Anderson	Madison
Pattison, John D.	Marion	Grant
Paul, Eudell G.	Munster	Lake
Paul, Leonard G.	Michigan City	La Porte
Pauly, Leonard R.	Fort Wayne	Allen
Paulissen, George T.	Indianapolis	Marion
Pauszek, Thomas B.	South Bend	St. Joseph
Pavlick, Theodore J.	Evansville	Vanderburgh
Payne, Arthur C.	East Chicago	Lake
Paynter, Morris B.	Southport	Marion
Paz, Luis	Shelbyville	Shelby
Peacock, Norman F.	Crawfordsville	Montgomery
Peacock, Robert C.	Muncie	Delaware-Blackford
Pearce, Roy V.	Terre Haute	Vigo
Pearcy, Marcene	Marion	Grant
Peare, Reeve B.	Huntington	Huntington
Pearson, Huey L.	Fort Wayne	Allen
Pearson, John S.	Indianapolis	Marion
Pearson, Lyman R.	Clearwater, Fla.	Marion
Pearson, William E.	Wabash	Wabash
Pebworth, Aubrey C. (S)	Chicago, Ill.	Marion
Peck, Edward A.	Hammond	Lake
Peck, Franklin B., Jr.	Indianapolis	Marion
Peck, Franklin B., Sr.	Monticello	Marion
Peck, James F.	Princeton	Gibson
Peiffer, Geraldine M.	Hammond	Lake
Peirce, James D.	Indianapolis	Marion
Pemberton, Jack J.	Evansville	Vanderburgh
Penn, Robert A.	East Gary	Lake
Pentecost, Paul S.	Richmond	Wayne-Union
Perdomo, Octavio J.	East Chicago	Lake
Perkins, Powell L.	Kokomo	Howard
Permer, Erwin	Indianapolis	Marion
Perrin, Kermit F.	Fort Wayne	Allen
Perry, Frederic G.	Fort Wayne	Allen
Person, Theodore C.	Veedersburg	Fountain-Warren
Peters, Elmer E.	Brookville	Fayette-Franklin
Peterson, Deward D.	Indianapolis	Marion
Peterson, Joel A.	Monticello	Tippecanoe
Peterson, Ronald L.	Plymouth	Marshall
Petitjean, Harold G.	Haubstadt	Gibson
Petranoff, Theodore V. (S)	Indianapolis	Marion
Petrass, Andrew (S)	South Bend	St. Joseph
Petrich, Peter R.	Attica	Fountain-Warren
Petry, T. Neal	Delphi	Carroll
Pettijohn, Fred L. (S)	Indianapolis	Marion
Pettis, Arthur G.	Gary	Lake
Peyton, Frank W.	Lafayette	Tippecanoe
Pfaff, Dudley A.	Indianapolis	Marion
Pfeifer, James M.	Lawrenceburg	Dearborn-Ohio
Pfuetze, Max E.	Logansport	Cass
Phares, Robert W.	Kokomo	Howard
Phelps, Stephen R.	South Bend	St. Joseph
Phelps, William J.	Fort Wayne	Allen
Philbert, Richard N.	Redwood City, Calif.	Allen
Philbrook, Seth S.	La Porte	La Porte
Phillips, David L.	Indianapolis	Marion
Phillips, John F.	Bluffton	Wells
Phillips, John H.	Michigan City	La Porte
Phipps, Elwood B.	Logansport	Cass
Phipps, Leland K.	Union City	Randolph
Pickett, Merle E.	Fort Wayne	Allen
Pickett, Robert D.	Indianapolis	Marion
Pierce, Emmett C., Jr.	Greenfield	Marion
Pierce, Fredrick H.	Danville, Ill.	Madison
Pierce, Gene S.	New Albany	Floyd
Pierce, Raymond O.	Indianapolis	Marion
Pierson, Howard	Gary	Lake
Pierson, Pearl H.	Silver Lake	Kosciusko
Pierson, Robert H.	Crawfordsville	Montgomery
Pierson, Thomas A.	New Palestine	Hancock
Pietz, David G.	Bluffton	Wells
Pike, Warren H.	Hobart	Lake
Pilcher, Jack E.	Indianapolis	Marion
Pilecki, Peter J.	Michigan City	La Porte
Pilot, Jean	Hammond	Lake
Pippenger, Joseph I.	Muncie	Delaware-Blackford
Pippenger, Wayne G.	Muncie	Delaware-Blackford

Name	City	County
Pirkle, Hubert B.	Rockville	Parke-Vermillion
Pitkin, McKendree C.	Martinsville	Morgan
Pittman, John N.	Ann Arbor, Mich.	Marion
Pizzo, Anthony	Bloomington	Owen-Monroe
Plain, George	South Bend	St. Joseph
Plank, C. Robert	Michigan City	La Porte
Plasterer, Edward D.	Richmond	Wayne-Union
Platis, James M.	Gary	Lake
Pletcher, William D.	Elkhart	Elkhart
Ploetner, Edward J.	Jasper	Dubois
Ploughe, Ralph R.	Elwood	Madison
Poehler, Fred C.	La Fontaine	Wabash
Poland, Maynard D.	Indianapolis	Marion
Polhemus, Warren C.	Anderson	Madison
Polite, Nicholas L.	Whiting	Lake
Pontius, Edwin E.	Indianapolis	Marion
Poolitsan, George C.	Bloomington	Owen-Monroe
Popp, Milton F.	Fort Wayne	Allen
Popplewell, Arvine G.	Indianapolis	Marion
Poracky, Bernard F.	Gary	Lake
Porro, Francis W.	Evansville	Vanderburgh
Porter, Carl M.	Jasonville	Greene
Porter, Edward A. (S)	Wesport	Decatur
Porter, George S.	Richmond	Wayne-Union
Porter, Jack	Lebanon	Boone
Porter, Robert A.	Indianapolis	Decatur
Portney, Fred R.	Munster	Lake
Poston, Clement L.	Laurel	Fayette-Franklin
Potter, Richard M.	Ridgeville	Randolph
Powell, J. Paxton	Marion	Grant
Powell, M. Jack	Fort Wayne	Allen
Powell, Richard C.	Indianapolis	Marion
Prather, Philip E.	Kokomo	Howard
Pratt, Ralph M., Jr.	Madison	Jefferson-Switzerland
Predd, Adolph C.	La Porte	La Porte
Premuda, Franklin F.	Hammond	Lake
Prentiss, Nelson H.	Oteen, N. C.	Allen
Present, Julian	Evansville	Vanderburgh
Price, Ambrose M.	Marion	Grant
Price, Douglas W.	Nappanee	Elkhart
Price, Francis W.	Indianapolis	Marion
Price, James O.	Indianapolis	Marion
Price, Shirley G.	Evansville	Vanderburgh
Price, Walter S.	Indianapolis	Marion
Priddy, Marvin E.	Fort Wayne	Allen
Priebe, Fred H.	Indianapolis	Montgomery
Proudfit, Charles H.	South Bend	St. Joseph
Province, Oran A.	Franklin	Johnson
Province, William D.	Franklin	Johnson
Pruitt, J. Edward	Gary	Lake
Pryor, Richard C.	Indianapolis	Marion
Pu, Pin H.	Terre Haute	Vigo
Pugh, Willis L.	Evansville	Vanderburgh
Pulskamp, Bertrand H.	Wolcottville	Noble
Purcell, Richard J.	Griffith	Lake
Puterbaugh, Karl E.	Albany	Delaware-Blackford
Pyle, Harold D.	South Bend	St. Joseph

Q

Quick, William J.	Muncie	Delaware-Blackford
Quickel, Daniel S. (S)	Anderson	Madison
Quigley, Joseph B.	Indianapolis	Marion
Quilty, Thomas J.	Goshen	Elkhart
Quitasol, Zoilo A., Jr.	Michigan City	La Porte

R

Rabb, Aaron	Louisville, Ky.	Marion
Rabb, Frank M.	Indianapolis	Marion
Rabb, Harry S.	Indianapolis	Marion
Raber, Robert M.	Indianapolis	Marion
Rader, George S.	Indianapolis	Marion
Radigan, Leo R.	Gary	Lake
Radpour, Shokri	Kokomo	Howard
Rafalski, Thomas A.	Indianapolis	Marion
Ragan, William D.	Indianapolis	Marion
Ralston, John D.	Indianapolis	Marion
Ramage, Walter F.	Beech Grove	Marion
Ramey, John W. (S)	Kokomo	Howard
Ramker, Daniel T.	Hammond	Lake
Ramos, John	East Chicago	Lake
Ramsdell, Glen A.	Richmond	Wayne-Union
Ramsey, Frank B.	Indianapolis	Marion
Ramsey, Hugh S.	Bloomington	Owen-Monroe
Ranck, Benjamin A.	Columbus	Bartholomew-Brown
Raney, Ben B.	Linton	Greene
Rang, A. A. (S)	Washington	Daviess-Martin
Rang, Robert H.	Washington	Daviess-Martin
Rank, William B.	Fort Wayne	Allen
Ransburg, Robert C.	Indianapolis	Marion
Rapp, George F.	Columbia, S. Carolina	Marion
Rasch, George C., Jr.	Munster	Lake
Rasmussen, Ruth F.	South Bend	St. Joseph
Ratcliff, Forest F.	Evansville	Vanderburgh
Ratcliff, Frank W.	Lafayette	Tippecanoe
Ratcliffe, Albert W.	Evansville	Vanderburgh
Rau, Charles A.	Columbus	Bartholomew-Brown
Rauh, Robert A.	Wabash	Wabash
Rausch, Norman W.	Angola	Steuben
Rawlins, Carolyn M.	Hammond	Lake
Rawls, George H.	Indianapolis	Marion
Raymundo, Vivencio F.	Attica	Fountain-Warren
Rea, Ralph L.	Argos	Marshall
Read, John E.	Chesterton	Porter
Records, Arthur W.	Franklin	Johnson
Records, John M.	Franklin	Johnson
Reed, Donald W.	Culver	Marshall
Reed, Edsel S.	Jeffersonville	Clark
Reed, Edgar A.	Warsaw	Kosciusko
Reed, John	Hobart	Lake
Reed, John D.	Fort Wayne	Allen
Reed, Nelle C. (S)	Michigan City	La Porte
Reed, Philip B.	Indianapolis	Marion
Reed, Robert C.	Terre Haute	Vigo
Reed, Robert F.	Mishawaka	St. Joseph
Reed, Robert G., Jr.	Plymouth	Marshall
Reed, Roger R.	Anderson	Madison
Reed, Roland R.	Whiting	Lake
Reed, Thomas E.	Indianapolis	Marion
Reeder, Henry H.	Jeffersonville	Clark
Rees, Russel C.	Indianapolis	Marion
Reese, Jay S.	Martinsville	Morgan
Regan, George L.	Sellersburg	Clark
Reibel, Donald B.	Beaufort, S. Carolina	Marion
Reich, Clarence E.	Evansville	Vanderburgh
Reid, Charles A.	Indianapolis	Marion
Reid, Donald B.	Columbia City	Whitley
Reid, James D.	Marion	Grant
Reid, Robert M.	Columbus	Bartholomew-Brown
Reid, Robert W. (S)	Union City	Randolph
Reilly, Eva F.	Beech Grove	Marion
Reilly, James F.	Vincennes	Knox
Reisler, Simon (S)	Indianapolis	Marion
Reitman, Paul H.	East Chicago	Lake
Remich, Antone C.	Hammond	Lake
Renbarger, Lester L.	Marion	Grant
Rendel, Donald T.	Hammond	Lake
Rendel, Harold E.	Mexico	Miami
Reno, Edward C.	Plymouth	Marshall
Repay, Walter A.	Hammond	Lake
Reppert, Roland L.	Decatur	Adams

Name	City	County
Ress, Gene E.	Tell City	Perry
Reuter, John W.	Bedford	Lawrence
Reynolds, James S.	Gary	Lake
Reynolds, Ralph E.	Middletown	Madison
Reynolds, Richard J.	Terre Haute	Vigo
Rhamy, Arthur P.	Marion	Grant
Rhamy, Donald E.	Indianapolis	Grant
Rhamy, Robert K.	Indianapolis	Marion
Rhea, Kenneth E.	FPO, New York, N. Y.	Marion
Rheinheimer, Floyd L.	Milford	Elkhart
Rhind, Alexander W.	Hammond	Lake
Rhodes, Alfred K.	Lawrenceburg	Dearborn-Ohio
Rhodes, Theodore D.	Nokomis, Fla.	Marion
Rhorer, Herbert M. (S)	Kokomo	Howard
Rhorer, John G.	Marion	Grant
Rhynearson, Hal R.	Fortville	Hancock
Ricchetti, Warren F.	Lafayette	Tippecanoe
Rice, Frederic A., Jr.	Indianapolis	Marion
Rice, Raymond D.	Indianapolis	Marion
Rice, Raymond M.	Indianapolis	Marion
Rice, Ronald B.	Indianapolis	Marion
Rich, Norval (S)	Decatur	Adams
Richard, Norman F.	Shelbyville	Shelby
Richards, Edgar E.	Russellville	Montgomery
Richardson, Charles L.	Rochester	Fulton
Richardson, Joseph D.	Rochester	Fulton
Richardson, Joseph H.	Marion	Grant
Richardson, Thad T.	Indianapolis	Marion
Richart, James V.	Terre Haute	Vigo
Richmond, Harold W.	Columbus	Bartholomew-Brown
Richter, Arthur B.	Indianapolis	Marion
Richter, John C.	La Porte	La Porte
Richter, Samuel	Gary	Lake
Ricketts, Joseph W. (S).	Orman Beach, Fla.	Marion
Ridgway, Alton H.	Lapel	Madison
Ridolfo, Anthony S.	Indianapolis	Marion
Rieger, I. Taylor	Bloomington	Owen-Monroe
Rietman, H. Jerome	Evansville	Vanderburgh
Rifner, Eugene S.	Van Buren	Grant
Rigg, John F. (S)	Miami Shores, Fla.	Marion
Riggs, Floyd C.	Terre Haute	Vigo
Riggs, Wendell A.	Lafayette	Tippecanoe
Rigley, Edward L.	South Bend	St. Joseph
Riley, Henry S.	Madison	Jefferson-Switzerland
Rimel, James F.	Plymouth	Marshall
Rinehart, James J.	Kokomo	Howard
Riner, Jack K.	Indianapolis	Marion
Rinne, John I. (S)	Lapel	Madison
Riordan, John F.	Gary	Lake
Ripley, John W.	Seymour	Jackson-Jennings
Rissing, Walter J.	Fort Wayne	Allen
Ritchie, William D.	Evansville	Vanderburgh
Ritchey, James O.	Indianapolis	Marion
Ritteman, George W.	Franklin	Johnson
Ritter, Wayne L.	Indianapolis	Marion
Ritz, Albert S.	Evansville	Vanderburgh
Rivers, Glynn A.	Muncie	Delaware-Blackford
Robb, John A.	Indianapolis	Marion
Roberts, Billy J.	South Bend	St. Joseph
Robertson, Addis N.	New Albany	Marshall
Robertson, James S.	Plymouth	Floyd
Robertson, Ray B.	Indianapolis	Marion
Robertson, William C.	Chesterton	Porter
Robertson, William S.	Spiceland	Henry
Robinson, Earle U.	Evansville	Vanderburgh
Robinson, Earl U., Jr.	Indianapolis	Marion
Robinson, Frank C. (S)	Newport Beach, Calif.	Marion
Robinson, Nan	New Albany	Floyd
Robinson, Walter K.	Gary	Lake
Robinson, William H.	Mitchell	Lawrence
Roby, Alma L.	Jeffersonville	Clark
Rochlin, Isidore	Indianapolis	Marion
Rockey, Noah A. (S)	Fort Wayne	Allen
Rodin, Herman H.	South Bend	St. Joseph
Roesch, Ryland P.	Indianapolis	Marion
Roeske, Nancy A.	Indianapolis	Marion
Rogers, Donald L.	Indianapolis	Marion
Rogers, Evered E.	Auburn	De Kalb
Rogers, Otto F., Jr.	Bloomington	Owen-Monroe
Rogers, R. Shirrell	Terre Haute	Vigo
Rogers, Thomas P.	La Jolla, Calif.	Marion
Rohn, Robert J.	Indianapolis	Marion
Rohrer, Bryce B.	Walkerton	La Porte
Rohrer, James R.	Elnora	Daviess-Martin
Roll, John W.	Indianapolis	Marion
Roller, Charles W. (S)	Indianapolis	Marion
Roller, Mac C.	Avon	Hendricks
Rollins, Thomas K.	Bloomington	Owen-Monroe
Romberger, Floyd T., Jr.	Indianapolis	Marion
Romero, Plinio	East Chicago	Lake
Rommel, Clarence H.	W. Lafayette	Tippecanoe
Roof, Roger S.	Spencer	Owen-Monroe
Roose, Lisle W.	Nappanee	Elkhart
Ropp, Eldon R. (S)	Oakland City	Gibson
Ropp, Harold E.	New Harmony	Posey
Rosato, Edward J.	Evansville	Vanderburgh
Rosenak, Bernard D.	Indianapolis	Marion
Rosenbaum, Irving, Jr.	Indianapolis	Marion
Rosenbaum, Lloyd E.	Anderson	Madison
Rosenberg, Gabriel J.	Indianapolis	Marion
Rosenblatt, Bernard B.	Evansville	Vanderburgh
Rosenbloom, Philip J.	Gary	Lake
Rosenheimer, George M.	South Bend	St. Joseph
Rosenthal, Carl	Hammond	Lake
Rosenwasser, Jacob	Mishawaka	St. Joseph
Roser, Arthur J.	Fort Wayne	Allen
Rosevear, Henry J.	Hammond	Lake
Ross, Alexander T.	Indianapolis	Marion
Ross, Ben R.	Bloomington	Owen-Monroe
Ross, David E., Jr.	Gary	Lake
Ross, Glenn E.	Washington	Daviess-Martin
Ross, Guy E.	Anderson	Madison
Ross, Harry P.	Richmond	Wayne-Union
Ross, James B.	Bloomington	Owen-Monroe
Rossiter, Dudley L.	Fort Wayne	Allen
Roth, Bertram S.	Indianapolis	Marion
Roth, James R.	Columbia City	Whitley
Roth, Leo	Gary	Lake
Roth, Melvin I.	Gary	Lake
Rothberg, Maurice	Fort Wayne	Allen
Rothrock, Philip W.	Lafayette	Tippecanoe
Rotman, Harry G.	Jasonville	Greene
Rotman, Sam I.	Jasonville	Greene
Rouen, Robert L.	Elkhart	Elkhart
Rougraff, Maurice E.	Indianapolis	Marion
Rourke, Robert F.	Terre Haute	Vigo
Rousseau, John W.	Fort Wayne	Allen
Row, D. Hamilton	Indianapolis	Marion
Row, George S.	Osgood	Ripley
Row, Perrie Q.	Hammond	Lake
Rowe, Howard H.	Rochester	Fulton
Royster, George M. (S)	Evansville	Vanderburgh
Royster, Robert A.	Evansville	Vanderburgh
Rubens, Eli	South Bend	St. Joseph
Rubin, Milton M.	Terre Haute	Vigo
Rubin, Simon S.	Gary	Lake
Rubright, Robert L.	Hammond	Lake
Ruby, Fred McK. (S)	Milwaukee, Wisc.	Randolph
Rucker, Warren R.	Madison	Jefferson-Switzerland
Ruddell, Karl R. (S)	Indianapolis	Marion
Ruddell, Keith R.	Indianapolis	Marion
Rudesill, Cecil L. (S)	Indianapolis	Marion

Name	City	County
Rudesill, Robert L.	Indianapolis	Marion
Rudicel, Max	Kokomo	Howard
Rudolph, Carl J.	South Bend	St. Joseph
Rudolph, Franklin G.	Munster	Lake
Rudolph, Kenneth J.	Evansville	Vanderburgh
Rudolph, Stephen J., Jr.	Cannon A.F.B., New Mexico	Marion
Rudser, Donald H.	Whiting	Lake
Rudy, Donald B.	Salisbury, S. Rhodesia	Wells
Runge, Paul W.	Richmond	Wayne-Union
Ruoff, William F.	New Albany	Floyd
Rupe, Lloyd O.	Elkhart	Elkhart
Rupel, Dennis F.	Elkhart	Elkhart
Rupel, Ernest (S)	Indianapolis	Marion
Rupper, Warren R.	Evansville	Vanderburgh
Rusche, Henry J.	Evansville	Vanderburgh
Ruschli, Edward B. (S)	Lafayette	Tippecanoe
Rusher, Merrill W.	Bluffton	Wells
Rusk, Hubert M.	Wallace	Fountain-Warren
Rusler, William J.	Rochester	Fulton
Russell, Henry T.	Lafayette	Tippecanoe
Russell, John R.	Indianapolis	Marion
Russell, Richard H.	Evansville	Vanderburgh
Russo, Andrew E.	Crown Point	Lake
Rust, Byron K.	APO 271, New York, N. Y.	Marion
Rust, Roland B.	Indianapolis	Marion
Ruth, Martin L.	Indianapolis	Marion
Rutherford, Charles E.	Indianapolis	Benton
Rutherford, Cyrus W. (S)	Indianapolis	Marion
Rutledge, Carl E., Jr.	Bowling Green, Ky.	Wells
Ryan, C. David	Indianapolis	Marion
Ryan, Glen V.	Indianapolis	Marion
Ryan, Hubert J.	Gary	Lake
Ryan, William J.	Columbus	Bartholomew-Brown

S

Sabens, James A.	Scottsburg	Scott
Sacks, Leonard Z.	Valparaiso	Porter
Sage, Charles V., Jr.	Richmond	Wayne-Union
Sage, Russell A.	Indianapolis	Marion
Sahlmann, Hans	Fort Wayne	Allen
Saint, William K.	New Castle	Henry
Sala, Joseph J.	Gary	Lake
Sala, Walter R.	Gary	Lake
Salb, John P.	Jasper	Dubois
Salb, Leo A. (S)	Jasper	Dubois
Salb, Max C.	Indianapolis	Marion
Salon, Harry W.	Fort Wayne	Allen
Salon, Joel W.	Fort Wayne	Allen
Salon, Nathan L.	Fort Wayne	Allen
Salzburg, Herbert E.	Westville	La Porte
Sanchez, Jose D.	La Porte	La Porte
Samter, Thomas G.	Indianapolis	Marion
Sanders, Bertram W.	Connersville	Fayette-Franklin
Sanders, Fred	Indianapolis	Marion
Sanders, Harry M.	Indianapolis	Marion
Sanders, Jesse A. (S)	Auburn	De Kalb
Sanders, Marilyn M.	Indianapolis	Marion
Sanderson, Robert B.	South Bend	St. Joseph
Sandock, Louis F.	South Bend	St. Joseph
Sandoz, Harry H.	South Bend	St. Joseph
Saperstein, Morris	Indianapolis	Marion
Santare, Vincent J.	Munster	Lake
Santiago, Iluminada	Highland	Lake
Sargent, Wallace B.	Hammond	Lake
Sarver, Francis E.	Fort Wayne	Allen
Savage, Arthur R.	Fort Wayne	Allen
Sayers, Frank E. (S)	Terre Haute	Vigo
Scales, Alfred B.	Huntingburg	Dubois
Scales, Allen D.	Huntingburg	Dubois
Scamahorn, Malcolm O.	Pittsboro	Hendricks
Scea, Wallace A.	Elwood	Madison
Schaaf, Alvin D.	Jamestown	Boone
Schafer, William C.	Washington	Daviess-Martin
Schaffer, Edward V.	Indianapolis	Marion
Schantz, Richard	Remington	Jasper
Schaphorst, Richard A.	Mishawaka	St. Joseph
Scharbrough, Wm. D.	Ewing	Jackson-Jennings
Schauwecker, Cleon M.	Greencastle	Putnam
Schechter, John S.	Indianapolis	Marion
Scheeringa, Ronald H.	Baltimore, Md.	Marion
Scheetz, Marion R.	Lewisville	Henry
Scheier, Emil W.	Indianapolis	Marion
Scheimann, Lois	Valparaiso	Porter
Schell, H. Richard	Bloomington	Owen-Monroe
Schellhouse, Earl M.	St. Louis, Mo.	Allen
Schenck, Foss (S)	Logansport	Cass
Schenck, Ralph E.	Portland	Jay
Scherb, Burton E.	Terre Haute	Vigo
Schermer, Kenneth L.	Indianapolis	Marion
Scherschel, John P.	Bedford	Lawrence
Scheurich, Virgil	Oxford	Benton
Schiller, Herbert A.	South Bend	St. Joseph
Schimmelpfennig, Robert W.	Evansville	Vanderburgh
Schirmer, Robert H.	Evansville	Vanderburgh
Schlademan, Karl R.	Fort Wayne	Allen
Schlaegel, Theo. F., Jr.	Indianapolis	Marion
Schlegel, Donald M.	Indianapolis	Marion
Schlemmer, George H.	Warsaw	Kosciusko
Schlesinger, Daniel J.	Hammond	Lake
Schloss, Robert P.	Fort Wayne	Allen
Schlosser, Herbert C.	Elkhart	Elkhart
Schmalhausen, Ansel W.	Indianapolis	Marion
Schmidt, Eugene E.	Fort Wayne	Allen
Schmidt, Loren F.	Indianapolis	Marion
Schmidt, Richard H.	Valparaiso	Porter
Schmiedicke, Paul H.	W. Lafayette	Tippecanoe
Schmitt, Richard K.	Columbus	Bartholomew-Brown
Schmitt, Robert J.	Munster	Lake
Schmitt, Robert W.	Richmond	Wayne-Union
Schmoll, Robert J.	Fort Wayne	Allen
Schmoyer, Maurice R.	Indianapolis	Marion
Schneck, Ralph E.	Portland	Jay
Schneider, Carl J.	Indianapolis	Marion
Schneider, Charles P.	Evansville	Vanderburgh
Schneider, Kenneth D.	Nashville	Bartholomew-Brown
Schneider, Louis A.	Fort Wayne	Allen
Schneider, Marvin C.	Rushville	Rush
Schneider, Paul A.	Indianapolis	Marion
Schnute, Richard B.	Indianapolis	Marion
Schoen, Frederic L.	Fort Wayne	Allen
Schoenhals, Charles E.	Fort Wayne	Allen
Schoolfield, William E.	Orleans	Orange
Schoonveld, Arthur	Brook	Newton
Schott, Edward J. (S)	Terre Haute	Vigo
Schreiner, John E.	Bremen	Marshall
Schrepferman, Wayne	Hamilton	Steuben
Schriefer, Victor V.	Evansville	Vanderburgh
Schroeder, Henry R., Jr.	Washington	Daviess-Martin
Schroeder, Robert W.	Marion	Grant
Schubert, Jerome C.	Fort Wayne	Allen
Schuchman, Abe	Indianapolis	Marion
Schuchman, Gabriel	Indianapolis	Marion
Schuerich, Virgil	Oxford	Benton
Schulfer, Richard J.	Hammond	Lake
Schulhof, Maurice G.	Muncie	Delaware-Blackford
Schultheis, Richard L.	Bloomington	Owen-Monroe

Name	City	County
Schulz, Kurt J.	Gary	Lake
Schumacher, Richard R.	Albany, Ga.	Marion
Schumaker, Robert A.	Terre Haute	Vigo
Schuman, Edith B.	Bloomington	Owen-Monroe
Schuster, Dwight W.	Indianapolis	Marion
Schwartz, Frederick C.	Kokomo	Howard
Schwartz, Jack	Munster	Lake
Schwartz, Mary M.	Hammond	Lake
Schwarz, Anton	Indianapolis	Marion
Schwarz, Mandel	Gary	Lake
Scofield, John B.	Indianapolis	Marion
Scoins, William H.	Fort Wayne	Allen
Scott, Frank M.	South Bend	St. Joseph
Scott, George E.	Indianapolis	Marion
Scott, H. Vaughn	Fort Wayne	Allen
Scott, Irvin H.	Sullivan	Sullivan
Scott, I. Winfield	Indianapolis	Marion
Scott, John S.	La Porte	La Porte
Scott, John R.	Indianapolis	Marion
Scott, Robert O.	Charlottesville	Hancock
Scott, Robert P.	Indianapolis	Marion
Scott, Samuel L.	Indianapolis	Marion
Scott, V. Brown	Shelbyville	Shelby
Scudder, Arthur N.	Brownsburg	Hendricks
Scudder, James P.	Fort Wayne	Allen
Scully, John T.	Gary	Lake
Scully, William E.	Terre Haute	Vigo
Seal, Perry F.	Brookville	Fayette-Franklin
Seaman, Charles F.	Indianapolis	Marion
Searight, John L.	Indianapolis	Marion
Sears, Don	Odon	Daviess-Martin
Sears, Murray M. (S)	Elkhart	Elkhart
Seat, Marshall H.	Washington	Daviess-Martin
Sedam, Herbert L.	Indianapolis	Marion
Seese, Robert M.	Delphi	Carroll
Segar, William E.	Indianapolis	Marion
Seibel, Robert M.	Nashville	Bartholomew-Brown
Seipel, Stanley	Lanesville	Harrison-Crawford
Selby, Keith E.	South Bend	St. Joseph
Sellers, Francis M.	South Bend	St. Joseph
Sellmer, George W.	Indianapolis	Marion
Senese, Thomas J.	Gary	Lake
Sennett, Cecil M. (S)	Westville	La Porte
Sennett, William K.	Macy	Miami
Senseny, Eugene F.	Fort Wayne	Allen
Serna, Carlos A.	East Chicago	Lake
Serna, Jesus A.	East Chicago	Lake
Seward, George W.	North Manchester	Wabash
Sexson, Hiram T.	Indianapolis	Marion
Seybert, Thomas C.	Indianapolis	Marion
Seyler, Anna G.	La Verne, Calif.	Lake
Shafer, Marion R.	Indianapolis	Marion
Shafer, Richard H.	Alexandria	Madison
Shaffer, Kenneth L.	Vincennes	Knox
Shaffer, William R.	Greensburg	Decatur
Shallenberger, Henry R.	Modoc	Randolph
Shanafelt, Donald K.	Indianapolis	Marion
Shanklin, Jack L.	Vincennes	Knox
Shanklin, Vernon A. (S)	Terre Haute	Vigo
Shanks, Ray W.	Noblesville	Hamilton
Shannon, Wesley E.	Crawfordsville	Montgomery
Shapiro, Burton J.	Indianapolis	Marion
Shapiro, Joseph	Hammond	Lake
Shapiro, Seymour W.	Hammond	Lake
Sharp, Merle C.	South Bend	St. Joseph
Sharp, William L.	Anderson	Madison
Shattuck, John C.	Brazil	Clay
Shaw, Houston W.	Jeffersonville	Clark
Shaw, James E.	Fort Wayne	Allen
Sheehan, E. Gregg	Evansville	Vanderburgh
Sheehan, Francis G.	Indianapolis	Marion
Sheek, Kenneth I.	Greenwood	Johnson
Sheets, Charles E.	Manilla	Rush
Sheldon, Suel A.	Anderson	Madison
Sheller, Tom G.	Logansport	Cass
Shelley, Edward S.	South Bend	St. Joseph
Shelley, Richard J.	Indianapolis	Marion
Shellhouse, Earl M.	Chillicothe, Ohio	Allen
Shellhouse, Michael	Gary	Lake
Shelton, Clyde F.	New Albany	Floyd
Shenk, Earl M. (S)	Kokomo	Howard
Shepard, Fred F.	College Corner, Ohio	Wayne-Union
Sherer, Kenneth E.	Richmond	Wayne-Union
Sherster, Harry	Indianapolis	Marion
Sherwood, Clarence E.	Madison, So. Dakota	Allen
Shevick, Alexander	Gary	Lake
Shields, Jack E.	Brownstown	Jackson-Jennings
Shields, Tom S.	Richmond	Wayne-Union
Shina, Hassi S.	Charlestown	Clark
Shinabery, Lawerence	Fort Wayne	Allen
Shipley, Edward	Indianapolis	Marion
Shively, John L.	Lafayette	Tippecanoe
Shively, Wyant J.	Evansville	Vanderburgh
Shoemaker, Richard L.	Gas City	Grant
Sholty, William M.	Lafayette	Tippecanoe
Short, John T. (S)	Fort Wayne	Allen
Shoup, Homer B. (S)	Greentown	Howard
Showalter, John P.	Angola	De Kalb
Showalter, John R.	Terre Haute	Vigo
Shrader, Carl E.	Warsaw	Kosciusko
Shriber, William H.	South Bend	St. Joseph
Shriner, Richard L.	South Bend	St. Joseph
Shrock, Ethan E.	Amboy	Miami
Shroyer, Herbert L.	Dunkirk	Jay
Shuck, William A.	Madison	Jefferson-Switzerland
Shugart, Robert R.	Fort Wayne	Allen
Shullenberger, Wendell A.	Indianapolis	Marion
Shulruff, Harry I.	East Chicago	Lake
Shultz, Clifford	Butler	De Kalb
Shumacker, Harris B., Jr.	Indianapolis	Marion
Sibbitt, Joseph W.	Bloomington	Owen-Monroe
Sicks, Okla W. (S)	Indianapolis	Marion
Sidebottom, Earl W.	Indianapolis	Marion
Sidell, James P.	New Haven	Allen
Siderys, Harry	Indianapolis	Marion
Siebe, Jack C.	Indianapolis	Marion
Siebenmorgen, Paul	Terre Haute	Vigo
Siekierski, Joseph M.	Griffith	Lake
Siersdorfer, Theodore N. (S)	Indianapolis	Marion
Sigmond, Harvey W.	Indianapolis	Marion
Sigmund, William B.	Columbus	Bartholomew-Brown
Silber, David L., Jr.	Elkhart	Elkhart
Silbert, David B.	Shelbyville	Shelby
Silver, Richard A.	Indianapolis	Marion
Silverman, Norman M.	Terre Haute	Vigo
Silvian, Harry A.	Whiting	Lake
Simmons, Frederick H.	Marion	Grant
Simmons, James E.	Indianapolis	Marion
Simmons, Lloyd H. (S)	Goshen	Elkhart
Simms, J. Leon	Indianapolis	Marion
Simpson, William D.	Indianapolis	Marion
Sims, J. Lawrence	Indianapolis	Marion
Singco, Bienvenido	Indianapolis	Marion
Singer, Elmer C. (S)	Fort Wayne	Allen
Sinn, Charles M.	Evansville	Vanderburgh
Sirugo, Aldo C.	La Porte	La Porte
Sirlin, Edward M.	Mishawaka	St. Joseph
Sisk, Phillip B.	Indianapolis	Marion
Sisson, Norvel D.	South Bend	St. Joseph
Sixbey, Maurice D.	Denver	Miami

Name	City	County
Skeen, Earl D. (S)	South Bend	Lake
Skillern, Penn G. (S)	South Bend	St. Joseph
Skillern, Scott D.	South Bend	St. Joseph
Skomp, Claud E.	Marion	Grant
Slama, George F.	Gary	Lake
Slama, John T.	Gary	Lake
Slaughter, Howard C.	Evansville	Vanderburgh
Slaughter, John C., Jr.	Evansville	Vanderburgh
Slaughter, Owen L.	Evansville	Vanderburgh
Slichenmyer, Jack E.	Indianapolis	Marion
Slick, Crystal R.	Winchester	Randolph
Sloan, Herbert P.	New Albany	Floyd
Sloan, W. Keith	Madison	Jefferson-Switzerland
Slominski, Harry H. (S)	South Bend	St. Joseph
Slomka, Myron B.	Indianapolis	Marion
Slough, O. Thomas	Indianapolis	Noble
Slough, Richard R.	Kendallville	Noble
Sluss, David H.	Indianapolis	Marion
Smith, A. Wilson	Greencastle	Putnam
Smith, Barton T.	Marion	Grant
Smith, Byron J.	Kingman	Fountain-Warren
Smith, Charles F.	Kokomo	Howard
Smith, David L.	Indianapolis	Marion
Smith, E. Rogers (S)	Indianapolis	Marion
Smith, Francis C.	Indianapolis	Marion
Smith, Fred, Jr.	Tell City	Perry
Smith, Frederick R.	Spencer	Owen-Monroe
Smith, Gloster J.	Kokomo	Howard
Smith, Gordon L.	Evansville	Vanderburgh
Smith, Herbert N.	Brookville	Fayette-Franklin
Smith, Herschel S.	Bloomington	Owen-Monroe
Smith, James S.	Muncie	Delaware-Blackford
Smith, Jerald E.	Hammond	Lake
Smith, John H.	Greenfield	Hancock
Smith, John R.	Richmond	Wayne-Union
Smith, Lee, Jr.	Lakeville	St. Joseph
Smith, Lloyd H.	North Manchester	Wabash
Smith, Lowell C.	Lafayette	Tippecanoe
Smith, Mark E.	New Castle	Henry
Smith, Philip L.	Fort Wayne	Allen
Smith, Ralph O.	Vincennes	Knox
Smith, Richard B.	Fort Wayne	Allen
Smith, Robert D.	Lowell	Lake
Smith, Rodney D. (S)	Bloomington	Owen-Monroe
Smith, R. Lee	Osgood	Ripley
Smith, Roger C.	Fort Wayne	Allen
Smith, Roy Lee (S)	Indianapolis	Marion
Smith, Roy M.	Evansville	Vanderburgh
Smith, S. Joseph	Vincennes	Knox
Smith, Stephen D.	Knightstown	Rush
Smith, Stephen M.	Montgomery, Ala.	Marion
Smith, Theodore J.	Whiting	Lake
Smith, William M.	Westville	La Porte
Smitley, Roger P.	Hammond	Lake
Smucker, Ernest E.	Goshen	Elkhart
Snapp, Richard A.	Columbus	Bartholomew-Brown
Sneary, Max E.	Avilla	Noble
Snider, Byron	Indianapolis	Marion
Snively, William D., Jr.	Evansville	Vanderburgh
Snodgrass, Robert E.	Greenwood	Johnson
Snowhite, Arthur B.	Marion	Grant
Snyder, Jerome A.	Munster	Lake
Snyder, Morris C.	Richmond	Wayne-Union
Snyder, Parker W.	Peru	Miami
Snyderman, Sanford C.	Fort Wayne	Allen
Sobol, Z. W.	Elkhart	Elkhart
Sokol, Allen B.	Whiting	Lake
Solis, Roger V.	Hammond	Lake
Solomon, Reuben A.	Indianapolis	Marion
Somers, Gerald H.	Fort Wayne	Allen
Somerville, J. W.	Clinton	Parke-Vermillion
Sonne, Irvin H., Jr.	New Albany	Floyd
Soper, Hunter A.	Indianapolis	Marion
Sorg, David A.	Bluffton	Wells
Souder, Bonnell M. (S)	Auburn	De Kalb
Souter, Martha C.	Indianapolis	Marion
Southard, Carl B.	Noblesville	Hamilton
Sovine, Joe W.	Indianapolis	Marion
Spahr, Donald E.	Portland	Jay
Spahr, John F., Jr.	Indianapolis	Marion
Spalding, Joseph J.	Indianapolis	Marion
Spalding, Wendell L.	Mishawaka	St. Joseph
Spangler, Jesse S.	Kokomo	Howard
Spangler, John S.	Indianapolis	Marion
Sparks, Alan L.	Indianapolis	Marion
Sparks, Paul W.	Winchester	Randolph
Spears, John K.	Paoli	Orange
Spears, John M.	Indianapolis	Marion
Speas, Robert C.	Terre Haute	Vigo
Speck, Carlson R.	Muncie	Delaware-Blackford
Speckman, Glenn H.	Indianapolis	Marion
Speer, Thomas A.	Gary	Lake
Spellman, Frank W.	Gary	Lake
Spencer, Beaufort A.	Bloomington	Owen-Monroe
Spencer, Frederic	Vincennes	Knox
Spencer, C. Herbert	Fort Wayne	Allen
Spenner, Raymond W.	South Bend	St. Joseph
Spindler, Robert D.	Shelbyville	Shelby
Spivack, Mary	Gary	Lake
Spolyar, Louis W.	Indianapolis	Marion
Spray, Page E.	Elkhart	Elkhart
Sprecher, Herman C.	Evansville	Vanderburgh
Sprecher, James J. J.	La Porte	La Porte
Springstun, George H.	Oaktown	Knox
Springstun, Walter R.	Evansville	Vanderburgh
Spurlock, Fae H.	W. Lafayette	Tippecanoe
Sputh, Carl B., Jr.	Indianapolis	Marion
Sroka, Stanley J.	Highland	Lake
Stadler, Harold E.	Indianapolis	Marion
Staff, Robert A.	Terre Haute	Parke-Vermillion
Stafford, William C.	Plainfield	Hendricks
Stahl, Edward T.	Lafayette	Tippecanoe
Stahl, Norman L.	Lawrenceburg	Dearborn-Ohio
Stallings, Hugh A.	Evansville	Vanderburgh
Stallman, Carl F.	Kendallville	Noble
Stalter, Gaylord W.	North Webster	Whitley
Stamper, Joseph H.	Anderson	Madison
Stamper, Robert J.	Anderson	Madison
Stander, Richard W.	Indianapolis	Marion
Stangle, William J.	Bloomington	Owen-Monroe
Stanley, Robert G.	Fort Wayne	Allen
Stansbury, William E.	Indianapolis	Marion
Stark, William A.	Michigan City	La Porte
Starks, William O.	Anderson	Madison
Stasick, Murray	Hammond	Lake
Stauffer, George E.	Mooreland	Henry
Stauffer, Richard C.	Fort Wayne	Allen
Stauffer, Walter A. (S)	Elkhart	Elkhart
Staunton, Henry A.	South Bend	St. Joseph
Stayton, Chester A., Jr.	Indianapolis	Marion
Steckbeck, Robert L.	Bluffton	Wells
Stecy, Peter	Whiting	Lake
Steele, Dick J.	Greencastle	Putnam
Steele, Everett B.	Crown Point	Lake
Steele, Frank M.	Muncie	Delaware-Blackford
Steele, Hugh H.	Lafayette	Tippecanoe
Steele, Paul W.	Evansville	Vanderburgh
Steen, Lowell H.	Whiting	Lake
Steffen, Julius T.	Wabash	Wabash
Steffy, Ralph M.	Portland	Jay
Steigmeyer, David J.	Fort Wayne	Allen
Stein, Richard H.	Vincennes	Knox
Steinem, Joseph L.	Connersville	Fayette-Franklin

Name	City	County
Steinmetz, Edward F.	Indianapolis	Marion
Stephens, Donald E.	Indianapolis	Marion
Stephens, James P.	Greencastle	Putnam
Stephens, Kuhrman H.	Indianapolis	Marion
Stephens, Lowell R.	Covington	Fountain-Warren
Stepleton, John D.	Richmond	Wayne-Union
Stern, Mona K.	East Gary	Lake
Stern, Samuel L.	Hammond	Lake
Sterne, John H.	Evansville	Vanderburgh
Steury, Ernest M.	Marion	Marion
Steussy, Calvin N.	New Castle	Henry
Stevens, Adam C.	Bluffton	Wells
Stevens, Edwin W.	Munster	Lake
Stevens, Sydney L.	Indianapolis	Marion
Stewart, J. Frank W.	Vincennes	Knox
Stewart, L. Ray	Evansville	Vanderburgh
Stewart, Walter E. (S)	Terre Haute	Vigo
Stibbins, Warren E.	Muncie	Delaware-Blackford
Stier, Paul L.	Fort Wayne	Allen
Stilwell, William R.	Richmond	Wayne-Union
Stine, Marshall E.	Bremen	Marshall
Stinson, Dean K.	Rochester	Fulton
Stinson, William M.	Anderson	Madison
Stiver, Daniel D.	South Bend	St. Joseph
Stoelting, J. Lewis	Terre Haute	Vigo
Stoelting, Vergil K.	Indianapolis	Marion
Stogdill, William J.	South Bend	St. Joseph
Stogsdill, Willis W.	Franklin	Johnson
Stoltz, Robert M.	Valparaiso	Porter
Stone, Alvin T.	Indianapolis	Marion
Stone, Robert C.	Ligonier	Noble
Stonier, Peter F.	Indianapolis	Marion
Stoops, Jean T.	Wabash	Wabash
Storey, D. Edmund	Indianapolis	Marion
Storey, Joseph L.	Indianapolis	Marion
Stork, Harvey K.	Huntingburg	Dubois
Stork, Urban F. D.	Evansville	Vanderburgh
Storms, Roy B. (S)	Indianapolis	Marion
Stouder, Albert E.	Kempton	Tipton
Stout, Francis E.	Muncie	Delaware-Blackford
Stout, Harry T.	Frankfort	Clinton
Stover, Wendell C.	Boonville	Warrick
Stoycoff, Christ M. (S)	Gary	Lake
Strang, William C.	Indianapolis	Marion
Stratigos, Joseph S.	South Bend	St. Joseph
Strayer, Joseph W.	Lafayette	Tippecanoe
Streck, Francis A.	Lawrenceburg	Dearborn-Ohio
Strecker, William L.	Terre Haute	Vigo
Streepey, Jefferson I.	New Albany	Floyd
Streeter, Ralph T.	Indianapolis	Marion
Stricker, Paul J.	New Castle	Henry
Strehler, Don A.	Bluffton	Wells
Strickland, James W.	Indianapolis	Marion
Strickland, Neil R.	Indianapolis	Marion
Stringer, Drennon D.	Mishawaka	St. Joseph
Strong, Daniel S. (S)	Terre Haute	Vigo
Strueh, Paul E.	Evansville	Vanderburgh
Stubbins, William M.	Elkhart	Elkhart
Stucky, Elsworth K.	Indianapolis	Marion
Stucky, Jerry L.	Fort Wayne	Allen
Studebaker, Lloyd R.	LaGrange	LaGrange
Stultz, Quentin F.	Ligonier	Noble
Stump, Loyd K.	Indianapolis	Marion
Stump, Richard L.	Muncie	Delaware-Blackford
Stump, Thomas A.	Indianapolis	Marion
Stumpf, Edwin E.	New Haven	Allen
Stuntz, Edgar C.	Lafayette	Tippecanoe
Sturgis, Donald G.	Sellersburg	Clark
Suelzer, John G.	Indianapolis	Marion
Suess, Robert E.	Indianapolis	Marion
Sugarman, Benjamin E.	French Lick Springs	Orange
Sullivan, Daniel R.	Oregon, Ohio	Randolph
Sullivan, James J.	Indianapolis	Marion
Sullivan, John M.	Terre Haute	Vigo
Sullivan, Robert E.	Fort Wayne	Allen
Summerlin, Jack D.	Indianapolis	Marion
Surratt, Mary Norris	Indianapolis	Marion
Sutton, William E.	Indianapolis	Marion
Suzuki, Tsutomu T.	Covington	Fountain-Warren
Swan, John R.	Indianapolis	Marion
Swank, Lucretia R.	Elkhart	Elkhart
Swanson, Roy A.	Muncie	Delaware-Blackford
Sweany, Stanford K.	Munster	Lake
Sweet, Howard E.	Richmond	Wayne-Union
Swihart, Danny D.	Elkhart	Elkhart
Swihart, Homer R.	Elkhart	Elkhart
Symmes, Alfred T.	Indianapolis	Marion
Symon, William E.	Bluffton	Wells
Szynal, John S.	Indianapolis	Marion

T

Tabaka, Francis B.	La Porte	La Porte
Tager, Stephen N.	Evansville	Vanderburgh
Takahashi, Masato	Indianapolis	Marion
Talarico, Leonard H.	Rochester, N. Y.	Marion
Talbert, Pierre C.	Bluffton	Wells
Talbott, Dan E.	Indianapolis	Marion
Tanner, Henry S.	Indianapolis	Marion
Tate, Elizabeth	Dunkirk	Jay
Taub, Robert G.	Michigan City	La Porte
Taube, Jack I.	Indianapolis	Marion
Taylor, Clifford C.	Indianapolis	Marion
Taylor, Donald R.	Muncie	Delaware-Blackford
Taylor, Everett C.	Upland	Grant
Taylor, Frederic W.	Indianapolis	Marion
Taylor, James A.	Anderson	Madison
Taylor, John R.	Palestine, Ill.	Sullivan
Taylor, M. Reed, Jr.	Howe	LaGrange
Taylor, Robert G.	Fort Wayne	Allen
Taylor, Wade H. (S)	Ambia	Benton
Teague, Frank W.	Indianapolis	Marion
Teal, Dorothy D.	Columbus	Bartholomew-Brown
Teegarden, Joseph A., Jr.	East Chicago	Lake
Teixler, Victor A.	Indianapolis	Marion
Templeton, Ames R.	Mishawaka	St. Joseph
Templeton, Ian S.	Seymour	Jackson-Jennings
Templin, David B.	Lowell	Lake
Tennant, David L.	Fort Wayne	Allen
Tepfer, Milton	Indianapolis	Marion
Teplinsky, Louis L.	East Chicago	Lake
TerBush, Edward L.	Logansport	Cass
Terrill, Richard W.	Fort Wayne	Allen
Terry, Lloyd S.	Danville	Hendricks
Terry, Robert H.	Boonville	Warrick
Test, Charles E.	Indianapolis	Marion
Teter, George V.	Indianapolis	Marion
Teters, Melvin S. (S)	Middlebury	Elkhart
Tether, Joseph E.	Indianapolis	Marion
Tetrick, Lain	Portage	Porter
Tharp, Donald W.	Muncie	Delaware-Blackford
Tharpe, Ray G.	Indianapolis	Marion
Thatcher, Hugh K., Jr.	Indianapolis	Marion
Thayer, Benet W.	North Vernon	Jackson-Jennings
Theobald, Sterling	Dyer	Lake
Thoman, Rex L.	Indianapolis	Marion
Thomas, Andrew C.	Hobart	Lake
Thomas, Charles R.	Indianapolis	Marion
Thomas, Daniel D.	Gary	Lake
Thomas, Edward P.	Indianapolis	Marion
Thomas, Everett W.	Warsaw	Kosciusko
Thomas, Fred A.	Indianapolis	Marion

Name	City	County
Thomas, Gerald J.	Gary	Lake
Thomas, Lowell I.	Indianapolis	Marion
Thomas, Morris E.	Indianapolis	Marion
Thomas, W. Clayton	Carmel	Hamilton
Thompson, Alfred A. (S)	Tyner	Marshall
Thompson, B. Jay	Marion	Grant
Thompson, Claude N.	Waynetown	Montgomery
Thompson, Edward C.	Greencastle	Putnam
Thompson, Frank M.	Columbia City	Whitley
Thompson, John M.	South Bend	St. Joseph
Thompson, John R.	Marion	Grant
Thompson, John V.	Indianapolis	Marion
Thompson, Joseph F.	Indianapolis	Marion
Thompson, Naiad Mason	Evansville	Vanderburgh
Thompson, Paul D.	Indianapolis	Marion
Thompson, Robert A.	South Bend	St. Joseph
Thompson, Wayne H.	Indianapolis	Marion
Thompson, Wm. R.	Winamac	Pulaski
Thorne, Charles E.	New Castle	Henry
Thornton, Harold C.	Indianapolis	Marion
Thornton, Maurice J.	South Bend	St. Joseph
Throop, Frank B.	Indianapolis	Marion
Thurston, Harrison S. (S)	North Webster	Marion
Tilden, Margaret H.	Evansville	Vanderburgh
Tiley, George A.	Greenwood	Johnson
Tilka, Edward C.	Hammond	Lake
Timmons, Gerald D.	Indianapolis	Marion
Tindall, George T.	Indianapolis	Marion
Tindall, William R.	Shelbyville	Shelby
Tinsley, Frank W.	Indianapolis	Marion
Tinsley, Walter B. (S)	Indianapolis	Marion
Tinsley, Walter B., Jr.	Indianapolis	Marion
Tipton, William R.	Greencastle	Putnam
Tirman, Wallace S.	South Bend	St. Joseph
Tischer, E. Paul	Indianapolis	Marion
Tisserand, John B., Jr.	Evansville	Vanderburgh
Todd, David D. (S)	LaJolla, Calif.	Elkhart
Tofaute, John L.	Indianapolis	Marion
Tolbert, Robert D.	Tampa, Fla.	Knox
Tomak, Milton E.	Linton	Greene
Tomlin, Hugh M.	Muncie	Delaware-Blackford
Tomusk, August N.	Fort Wayne	Allen
Tondra, John M.	Indianapolis	Marion
Topolgus, James N.	Bloomington	Owen-Monroe
Topping, Malachi C.	Terre Haute	Vigo
Torella, Jose A.	Indianapolis	Marion
Toumey, Fred L.	Indianapolis	Marion
Tower, James H., Jr.	Shelbyville	Shelby
Tower, Thomas K.	Campbellsburg	Washington
Townsend, James C.	Indianapolis	Marion
Trachtenberg, Lee	Munster	Lake
Tranter, William F.	Sharpsville	Tipton
Traver, Perry C. (S)	South Bend	St. Joseph
Tremain, Milton A. (S)	Adams	Decatur
Treon, James F. (S)	Aurora	Dearborn-Ohio
Trepagnier, Francis B.	E. Chicago	Lake
Trier, Herbert P.	Fort Wayne	Allen
Trimble, John G.	Kokomo	Howard
Trout, Carl J.	Lafayette	Tippecanoe
Troutwine, William R.	Crown Point	Lake
Troy, Jack M.	Whiting	Lake
Troyer, Dana O.	Goshen	Elkhart
Troyer, George W.	Goshen	Elkhart
Trudgen, Spencer F.	Indianapolis	Marion
Trusler, H. Marshall	Indianapolis	Marion
Trusler, Harold M.	Indianapolis	Marion
Tsatsos, George C.	Hartford, Conn.	Lake
Tubbs, George R. (S)	Lafayette	Tippecanoe
Tuchman, Joseph H.	Indianapolis	Marion
Tucker, Warren S.	Indianapolis	Marion
Tuholski, James M.	Evansville	Vanderburgh
Tunnell, Harry D.	Michigan City	La Porte
Turgi, Robert W.	Gary	Lake
Turley, Verne L. (S)	Fowler	Benton
Turner, Anna Goss	Madison	Jefferson-Switzerland
Turner, Harold B. (S)	Bloomfield	Greene
Turner, Isabel B.	Evansville	Vanderburgh
Turner, Jack J.	Bloomfield	Greene
Turner, John P.	Goshen	Elkhart
Turner, Oscar A. (S)	Madison	Jefferson-Switzerland
Tweedall, Daniel C.	Evansville	Vanderburgh
Tyler, Edward A.	Indianapolis	Marion
Tyler, Frank T. (S)	New Albany	Floyd
Tyner, Harlan H.	Indianapolis	Marion
Tyrrell, Joseph J.	Calumet City, Ill.	Lake
Tyrrell, Thomas C.	Calumet City, Ill.	Lake

U

Ullom, Ralph B.	Indianapolis	Marion
Ulrey, Robert P.	Elwood	Madison
Underwood, George M.	Lafayette	Tippecanoe
Ungemach, Willo F.	Fort Wayne	Allen
Urruti, Arnoldo H.	South Bend	St. Joseph
Urschel, Dan L.	Mentone	Kosciusko

V

Vagner, S. Bernard	South Bend	St. Joseph
Valencia, Monico	East Gary	Lake
Van Bokkelen, Robert W.	Mooresville	Morgan
Van Buskirk, Edmund L.	Lafayette	Tippecanoe
Van Campen, Warren M.	Huntington	Huntington
Van Denbark, Howard M.	Indianapolis	Marion
Van Den Bosch, Wallace R.	Lafayette	Tippecanoe
Vandivier, Robert M.	Indianapolis	Marion
Van Dorn, Myron J.	Indianapolis	Marion
Van Fleet, Josephine	Indianapolis	Marion
Van Fleit, William E.	South Bend	St. Joseph
Van Kirk, John R.	W. Lafayette	Tippecanoe
Van Kirk, Paul P.	Frankfort	Clinton
Van Meter, C. Powell	Indianapolis	Marion
Van Ness, William C.	Summitville	Madison
Van Rie, Leo P. (S)	Mishawaka	St. Joseph
Van Sandt, Frank A. (S)	Bloomfield	Greene
Van Tassel, Charles J.	Indianapolis	Marion
Van Vactor, Helen D.	Indianapolis	Marion
Van Wienen, John	Martinsville	Morgan
Vaughn, Walter R.	Vincennes	Knox
Veach, Lester W.	Bainbridge	Putnam
Veach, Richard L.	Bainbridge	Putnam
Veach, William L.	Terre Haute	Vigo
Vellios, Frank	Indianapolis	Marion
Venables, Albert J.	Evansville	Vanderburgh
Venis, Kemper N.	Muncie	Delaware-Blackford
Vergara, Abelardo	East Chicago	Lake
Vermilya, Robert W.	Lafayette	Tippecanoe
Verplank, Grover L. (S)	Gary	Lake
Viehe, Robert W. (S)	Evansville	Vanderburgh
Vietzke, Paul C. F.	Valparaiso	Porter
Vigor, David N.	Indianapolis	Marion
Vingis, Bronie A.	Greenfield	Hancock
Viney, Charles L.	Logansport	Cass
Viray, Victoriano G.	Crawfordsville	Montgomery
Visher, John W. (S)	Evansville	Vanderburgh
Vivian, Donald E.	New Castle	Henry
Vlaskamp, Elaine M.	Muncie	Delaware-Blackford
Vogel, John L.	Columbia City	Whitley
Vogel, Lloyd A., Jr.	Fort Wayne	Allen
Vogel, L. John	Mount Vernon	Posey
Voges, Edward C.	Terre Haute	Vigo

Name	City	County
Vollrath, Victor J.	Indianapolis	Marion
von Asch, George	La Porte	La Porte
von der Lieth, Wm. C.	Vincennes	Knox
Von Der Haar, Gerard	Indianapolis	Marion
Vonder Haar, Thomas E.	Evansville	Vanderburgh
Voorhees, Robert J.	Clayton, Mo.	Allen
Voorhies, McKinley	Gary	Lake
Vore, Hugh A.	Highland	Lake
Vore, Louring W.	Plymouth	Marshall
Vore, Robert E.	Indianapolis	Marion
Vormohr, Joseph F.	Portland	Jay
Voss, Gert	Muncie	Delaware-Blackford
Voyles, Harry E.	New Albany	Floyd
Vurpillat, Francis J.	South Bend	St. Joseph

W

Wachob, Tom W., Jr.	Kokomo	Howard
Wack, James E.	South Bend	St. Joseph
Wade, Reynolds W.	New Haven	Allen
Wagner, Anabel R.	Lafayette	Tippecanoe
Wagner, Arthur L.	Jasper	Dubois
Wagner, David G.	Goshen	Elkhart
Wagner, Lindley H.	Lafayette	Tippecanoe
Wagner, Richard	Huntington	Huntington
Wagoner, B. D.	Union City	Randolph
Wagoner, George W.	Delphi	Carroll
Wagoner, John R.	Anderson	Madison
Wainscott, Clinton S.	Indianapolis	Marion
Wait, Jerome H.	Columbia City	Whitley
Waits, Chester L.	Lafayette	Tippecanoe
Waitt, Paul	Sheridan	Hamilton
Walden, Heinz J.	Terre Haute	Vigo
Waldo, Guy H.	Bedford	Lawrence
Waldo, J. Thayer	Indianapolis	Marion
Walerko, Frank M.	Mishawaka	St. Joseph
Walker, Adolph P.	East Chicago	Lake
Walker, Edwin M., Jr.	South Bend	St. Joseph
Walker, Floyd B.	Fort Wayne	Allen
Walker, Jack M.	Muncie	Delaware-Blackford
Walker, James L. (S)	La Fontaine	Wabash
Walker, Louis	Greensburg	Decatur
Walker, Thomas M.	Brownsburg	Hendricks
Wallace, Collins R.	Fort Wayne	Allen
Wallace, Elmer L.	New Albany	Floyd
Wallace, Hawthorne C.	Crawfordsville	Montgomery
Walter, Paul A. F. III	Evansville	Vanderburgh
Walter, Robert F.	Evansville	Vanderburgh
Walters, Charles E.	Mishawaka	St. Joseph
Walters, Edward W.	Indianapolis	Marion
Walters, Eleanor	Gary	Lake
Walters, Jack L.	Franklin	Johnson
Walters, William H.	Michigan City	La Porte
Walther, Joseph E.	Indianapolis	Marion
Walton, R. Lee	Marion	Grant
Walton, William M.	Indianapolis	Marion
Wang, Tieh C.	East Chicago	Lake
Wanninger, Horace	Richmond	Wayne-Union
Warbinton, Fred P.	Plainfield	Hendricks
Ward, Gerald F.	Fort Wayne	Allen
Ward, James W.	South Bend	St. Joseph
Ward, Paula B.	Fort Wayne	Allen
Ward, Wesley C.	Indianapolis	Marion
Ware, Herbert E.	Muncie	Delaware-Blackford
Ware, John R.	Russiaville	Howard
Warfield, Chester H.	Fort Wayne	Allen
Warman, Alvah P. (S)	Indianapolis	Marion
Warn, William J.	Milan	Ripley
Warneke, Charles H.	Indianapolis	Marion
Warner, Charles L.	Evansville	Vanderburgh
Warren, Carroll B.	Marion	Grant
Warren, Lewis T.	Michigan City	La Porte
Warrick, Francis B.	Richmond	Wayne-Union
Warrick, Homer L.	Osceola	St. Joseph
Warriner, James B.	Indianapolis	Marion
Warshaw, Seymour	Columbus	Bartholomew-Brown
Warvel, John H., Jr.	Indianapolis	Marion
Warvel, John H. (S)	Indianapolis	Marion
Washington, G. Kenneth	Gary	Lake
Washington, Wilbert	Indianapolis	Marion
Wasserman, Don H.	Indianapolis	Marion
Waters, George E.	Evansville	Vanderburgh
Watterson, Gerald T.	Connersville	Fayette-Franklin
Way, James A.	Bloomington	Owen-Monroe
Waymire, William M.	Franklin	Johnson
Webb, Harry D.	Anderson	Madison
Webb, Lawrence C.	Dana	Parke-Vermillion
Weber, Edgar H.	Evansville	Vanderburgh
Weber, John R.	Fort Wayne	Allen
Weber, Joseph G. S.	Terre Haute	Vigo
Webster, Paul L.	Lafayette	Tippecanoe
Webster, Robert K.	Brazil	Clay
Weddle, Chas. O.	Lebanon	Boone
Weeks, Patrick H. (S)	Michigan City	La Porte
Weems, Mallory P.	Jeffersonville	Clark
Wehrman, Jule O. (S)	Indianapolis	Marion
Weigand, Clayton G.	Indianapolis	Marion
Weinbaum, Jack G.	Terre Haute	Vigo
Weinberg, Benjamin A.	Whiting	Lake
Weinberg, Samuel	Marion	Grant
Weinland, George C.	Columbus	Bartholomew-Brown
Weinstein, Edwin B.	Richmond	Wayne-Union
Weinstock, Adolph	Rolling Prairie	La Porte
Weirich, Charles I.	Butler	De Kalb
Weisenberger, Brockton L.	Lawrenceburg	Dearborn-Ohio
Weiskopf, Henry S.	Gary	Lake
Weisner, Richard M.	Muncie	Delaware-Blackford
Weiss, Albert E.	Michigan City	La Porte
Weiss, Eugene	South Bend	St. Joseph
Weiss, Henry G. (S)	Evansville	Vanderburgh
Weiss, Jason	Indianapolis	Marion
Weiss, John T.	Hobart	Lake
Weiss, Louis L.	Anderson	Madison
Weissman, Charles G.	Hammond	Lake
Weitemier, Raymond A.	Richmond	Wayne-Union
Weitzel, Roland E.	Princeton	Gibson
Welborn, Mell B.	Evansville	Vanderburgh
Welch, Norbert M.	Vincennes	Knox
Weldy, Bryce P.	Hartford City	Delaware-Blackford
Weller, Charles A. (S)	Indianapolis	Marion
Weller, Ralph D.	Rossville	Clinton
Weller, Wendell A.	Lafayette	Tippecanoe
Wells, William R.	Princeton	Gibson
Wenger, James E.	Nappanee	Elkhart
Wenzler, Paul J.	Bloomington	Owen-Monroe
Werry, Leslie E. (S)	Hartford City	Delaware-Blackford
Wertenberger, Morris D.	Richmond	Wayne-Union
Wesemann, Merrill M.	Franklin	Johnson
West, Joseph L.	Indianapolis	Marion
Westerman, Richard L.	Evansville	Vanderburgh
Westfall, B. Kemper	Indianapolis	Marion
Westfall, George S.	Goshen	Elkhart
Westfall, John B.	Indianapolis	Marion
Westhaysen, Peter V.	Munster	Lake
Wharton, Russell O. (S)	Gary	Lake
Wheeler, Byron C.	Terre Haute	Vigo
Wheeler, David E.	Indianapolis	Marion
Whipps, Charles E. (S)	Carlisle	Sullivan
Whisler, Frederick M. (S)	Wabash	Wabash
Whitaker, Jack	Gary	Lake
Whitcomb, Roger F.	Shelbyville	Shelby

Name	City	County
White, Chester S. (S)	Rosedale	Parke-Vermillion
White, Donald G.	South Bend	St. Joseph
White, Donald J.	Indianapolis	Marion
White, Douglas H.	Indianapolis	Marion
White, Gilbert H., Jr.	Hammond	Lake
White, Harvey E.	Farmland	Randolph
White, Isaac D. (S)	Clinton	Parke-Vermillion
White, James V.	Terre Haute	Vigo
White, John B., Jr.	Indianapolis	Marion
White, John P., Jr.	Indianapolis	Marion
Whitlock, Francis C.	Mishawaka	St. Joseph
Whitlock, Merle E.	Mishawaka	St. Joseph
Wiatt, Leonard H.	Knightstown	Henry
Wible, James H.	Kokomo	Howard
Wick, Alfred A.	Fort Wayne	Allen
Wickstrom, Otto W.	Columbus	Bartholomew-Brown
Widdifield, G. E.	Indianapolis	Marion
Wierzalis, Edward F.	Fort Wayne	Allen
Wiethoff, Clifford A.	Seymour	Jackson-Jennings
Wigh, Russell	Columbus	Bartholomew-Brown
Wiland, Olin K.	Richmond	Wayne-Union
Wilder, Gordon B.	Anderson	Madison
Wilhelm, Agatha M.	South Bend	St. Joseph
Wilhelm, Guido P.	New Castle	Henry
Wilhelmus, C. Kenneth	Evansville	Vanderburgh
Wilhelmus, Charles M. (S)	Newburgh	Warrick
Wilhelmus, Gilbert M.	Evansville	Vanderburgh
Wilkens, Irvin W.	Indianapolis	Marion
Willan, Horace R. (S)	Martinsville	Morgan
Williams, Berniece M.	Fort Wayne	Allen
Williams, Alexander S.	Gary	Lake
Williams, Charles D.	Indianapolis	Marion
Williams, Clifford L.	Indianapolis	Marion
Williams, Earl K.	Frankfort	Clinton
Williams, Edwin D.	Gary	Lake
Williams, Everett W.	Columbus	Bartholomew-Brown
Williams, Francis M.	Anderson	Madison
Williams, Fred R.	Gary	Lake
Williams, Fielding P.	Huntingburg	Dubois
Williams, Harold W.	Indianapolis	Marion
Williams, Howard S.	Indianapolis	Marion
Williams, Hugh L.	Indianapolis	Marion
Williams, John H.	Shipshewana	LaGrange
Williams, Paul A.	Rensselaer	Jasper
Williams, Paul D.	Indianapolis	Marion
Williams, Robert D.	Markleville	Madison
Williams, Robert H.	Anderson	Madison
Willis, Charles F.	Evansville	Vanderburgh
Willison, George W.	Evansville	Vanderburgh
Willner, Alan	Clarksville	Clark
Wills, Max	Auburn	De Kalb
Wilmore, Ralph C.	Indianapolis	Marion
Wilms, John H.	W. Lafayette	Tippecanoe
Wilson, David	Evansville	Vanderburgh
Wilson, David O.	Ft. McClellan, Ala.	Marion
Wilson, Edward A.	Richmond	Wayne-Union
Wilson, Fred L.	Terre Haute	Vigo
Wilson, Fred M.	Indianapolis	Marion
Wilson, Guy H.	Bicknell	Knox
Wilson, James M.	South Bend	St. Joseph
Wilson, John	Columbia City	Whitley
Wilson, John D.	Evansville	Vanderburgh
Wilson, Ned A.	Marion	Grant
Wilson, Oliver R.	Morgantown	Marion
Wilson, Orley E.	Elkhart	Elkhart
Wilson, Paul E. (S)	Boonville	Warrick
Wilson, Paul H.	Logansport	Cass
Wilson, Ralph	Evansville	Vanderburgh
Wilson, Roland B.	Fort Wayne	Allen
Wilson, Talmage L.	Bloomington	Owen-Monroe
Wilson, Wymond B.	Mentone	Kosciusko
Wimmer, Robert N. (S)	Gary	Lake
Winklepleck, A. M.	Connersville	Fayette-Franklin
Winter, Donald K.	Logansport	Cass
Winter, William P.	Martinsville	Morgan
Wirey, Harold R.	Indianapolis	Marion
Wise, Charles L.	Camden	Carroll
Wise, William R.	Indianapolis	Marion
Wiseheart, Oscar H. (S)	North Salem	Hendricks
Wiseheart, Robert H.	Lebanon	Boone
Wiseman, V. Earle	Greencastle	Putnam
Wishard, Wm. N., Jr.	Indianapolis	Marion
Witham, Robert L.	Indianapolis	Marion
Witt, William R.	Jeffersonville	Clark
Wixted, John F.	South Bend	St. Joseph
Wixted, Julia F.	South Bend	St. Joseph
Woerner, Thomas E.	Indianapolis	Marion
Wohlfeld, Gerald M.	Terre Haute	Vigo
Wohlfeld, Julius B.	Bedford	Lawrence
Wojcik, Ladislas D.	Marion	Grant
Wolf, William E.	La Porte	La Porte
Wolfe, Morton F.	New Albany	Floyd
Wolfe, Nelson A.	New Albany	Floyd
Wolfram, Don J.	Indianapolis	Marion
Wolverton, George M.	Clarksville	Clark
Woner, John W.	Linton	Greene
Wong, Norman F.	Linden	Tippecanoe
Wong, Samuel N.	Hammond	Lake
Wood, Donald E.	Indianapolis	Marion
Wood, Opal L.	Brazil	Clay
Woodard, Abram S., Jr.	Indianapolis	Marion
Woodbury, Clarence R.	Anderson	Madison
Woodbury, John W.	Marion	Grant
Wooden, Thomas F.	Munster	Lake
Woods, Arba L. (S)	Evansville	Posey
Woods, James R., Jr.	Greenfield	Hancock
Woods, Wm. P. (S)	Evansville	Vanderburgh
Woodson, Dan E.	Evansville	Vanderburgh
Woodward, Ben E.	Evansville	Vanderburgh
Woolery, Richard H.	Bedford	Lawrence
Woolling, Kenneth R.	Indianapolis	Marion
Work, Bruce A., Jr.	Ann Arbor, Mich.	Clinton
Work, James A., Jr. (S)	Elkhart	Elkhart
Worley, Ansel C.	Fort Wayne	Allen
Worley, Henry L.	New Albany	Floyd
Worley, Joseph P.	Indianapolis	Marion
Worley, Richard H.	Indianapolis	Marion
Worth, C. Willard	Milroy	Rush
Wrege, Malcolm L.	Indianapolis	Marion
Wright, Cecil S.	Anderson	Madison
Wright, James J.	Indianapolis	Marion
Wright, J. Wm., Jr.	Indianapolis	Marion
Wright, Wm. C.	Fort Wayne	Allen
Wu, Stewart	Valparaiso	Porter
Wurster, Herbert C.	Mishawaka	St. Joseph
Wyatt, James L., III	Fort Wayne	Allen
Wynegar, David E.	Richmond	Wayne-Union
Wynn, Justice F.	Evansville	Vanderburgh
Wyttenbach, John E.	Indianapolis	Marion

Y

Yacko, Michael L.	Indianapolis	Marion
Yale, Charles A.	Fairmount	Grant
Yanson, Mannfredo R. S.	Oxnard, Calif.	Lake
Yast, Charles J.	Gary	Lake
Yegerlehner, Roscoe S.	Kentland	Newton
Yingling, Robert J.	Indianapolis	Marion
Yocum, Paul S., Sr.	Gary	Lake
Yocum, Paul S., Jr.	Gary	Lake
Yocum, William S.	Gary	Lake
Yoder, C. Richard	Elkhart	Elkhart
Yoder, Dewey D.	Pierceton	Whitley
Yoder, Jonathan G.	Middlebury	Elkhart

Name	City	County
Yoder, Richard P.	Bluffton	Wells
Young, C. Curtis	Evansville	Vanderburgh
Young, George M.	Gary	Lake
Young, Gerald S.	Muncie	Delaware-Blackford
Young, James W.	Indianapolis	Marion
Young, John E.	Indianapolis	Marion
Young, John M.	Indianapolis	Marion
Young, John T.	Indianapolis	Marion
Young, Joseph W.	Greenwood	Johnson
Young, Ralph H.	Goshen	Elkhart
Young, Robert G.	Marion	Grant
Young, Robert L.	Gary	Lake
Youngs, Paul E.	Georgetown	Floyd
Yunker, Philip E.	Howe	LaGrange

Z

Zalac, Donald A.	Michigan City	La Porte
Zallen, Stanley G.	East Chicago	Lake
Zaring, Byron K.	Columbus	Bartholomew-Brown
Zehr, Noah (S)	Fort Wayne	Allen
Zeier, Francis G.	Evansville	Vanderburgh
Zeiger, Irvin L.	South Bend	St. Joseph
Zeitler, Philip S.	Elkhart	St. Joseph
Zell, Evertson H.	Indianapolis	Marion
Zeman, Ruth E.	Indianapolis	Marion
Zeps, E. Frances	Indianapolis	Marion
Zerfas, Charles P. A.	Beech Grove	Marion
Zerfas, Phyllis K.	Indianapolis	Marion
Zimmer, Henry J.	Mishawaka	St. Joseph
Zimmerman, Harold	Evansville	Vanderburgh
Zimmerman, Wm. H.	Syracuse	Elkhart
Zink, Robert O.	Madison	Jefferson-Switzerland
Ziperman, H. Haskell	APO 403, New York, N. Y.	Marion
Ziss, Robert C.	Evansville	Vanderburgh
Zore, Joseph J.	Richmond	Wayne-Union
Zucker, Edward	Gary	Lake
Zweig, Elmer S.	Fort Wayne	Allen
Zwerner, Paul F.	Terre Haute	Vigo
Zwick, Harold F.	Decatur	Adams
Zwickel, Ralph E.	Evansville	Vanderburgh
Zydlo, Stanley M.	Wabash	Wabash

ROSTER OF MEMBERS BY COUNTIES

Physicians are listed in the county medical society in which they hold membership.

(Paid-up members of the Indiana State Medical Association as of May 1, 1964.)

ADAMS COUNTY

Berne

Beaver, Norman E. 165 W. Water St.
Boze, Robert L. 265 W. Water St.
Dester, Herbert E. (S).....424 Compromise St.
Luginbill, Howard M.....165 S. Jefferson

Decatur

Burk, James M.....115 N. Third St.
Carroll, John C.....226 S. Second St.
Doan, John E. 222 S. Second St.
Freeby, C. William.....227 S. Second St.
Girod, Arthur H.....203 N. 12th St.
Kohne, Gerald J.....134 S. Third St.
Parrish, Richard K.....238 S. Second St.
Reppert, Roland L.....222 S. Second St.
Rich, Norval S.....415 W. Madison
Zwick, Harold F.....227 S. Second St.

ALLEN COUNTY

Fort Wayne

A

Adams, E. Wade.....3124 E. State Blvd.
Ahlbrand, Roland C.....1417 N. Anthony Blvd.
Aiken, Arthur F.....1923 E. State Blvd.
Aiken, Nevin E.....1923 E. State Blvd.
Anderson, Ernest.....4349 S. Anthony Blvd.
Andrew, Jerald L.....2423 S. Calhoun St.
Arata, James A.....730 W. Berry St.
Arata, Justin E.....3124 E. State Blvd.
Ashman, William C.....2902 S. Fairfield Ave.
Aust, Charles H.....Lutheran Hospital

B

Bahr, Robert E.....533 W. Washington St.
Bailey, Paul P.....206 Medical Center Bldg.
Ball, John R. 320 Medical Center Bldg.
Ball, Margaret Jane.....4112 S. Harrison St.
Baltes, Joseph H.....821 Broadway
Barch, John W.....1301 S. Harrison St.
Bash, Wallace E.....2902 Fairfield Ave.
Baumgartner, Jeraldine.....515½ W. Wayne St.
Beams, Ralph H.....715 Medical Center Bldg.
Beierlein, Karl M.....3124 E. State Blvd.
Beights, Raymond S.....3310 E. State Blvd.
Bergendahl, Emil H.....102 Medical Center Bldg.
Berghoff, James R.....306 Jefferson St.
Beutler, Theodore V.....527 W. Berry St.
Billingsley, John S.....2902 Fairfield Ave.
Blichert, Peter A.....424 Medical Center Bldg.
Bolman, Ralph M.....717 Broadway
Bossard, John W.....115 Medical Center Bldg.
Bowers, Gah T.....1417 N. Anthony Blvd.
Bowers, George W.....2902 Fairfield Ave.
Bowers, Jesse W. (S).....418 Gettle Bldg.
Brandt, William E.....228 Medical Center Bldg.
Braunlin, Robert J.....418 Medical Center Bldg.
Bridges, William L.....520 Medical Center Bldg.
Bromley, Luman W.....2730 E. State Blvd.
Brosius, Robert H. W.....1603 Wells St.
Brown, Frederic W.....2609 Fairfield Ave.
Brucker, Perry A.....304 Medical Center Bldg.
Bryan, Franklin A.....512 Medical Center Bldg.
Buckner, George D.....1003 Fulton St.
Burkhart, Charles A.....1301 S. Harrison St.

C

Carlo, Ernest R. (S).....2902 Fairfield Ave.
Cartwright, Emor L. (S)....3718 Hiawatha Blvd.
Chambers, Alan R.....601 W. Wayne St.
Chase, James A.....1635 Broadway
Clark, William R.....3622 S. Calhoun St.
Cochran, Harry A. Jr.....1301 S. Harrison St.
Conley, John E.....620 W. Berry St.
Connelly, Richard D.....3124 E. State Blvd.
Cooney, Charles J.....527 W. Berry St.
Cottrell, Robert F.....234 Medical Center Bldg.
Craig, Richard M.....2902 Fairfield Ave.
Culp, John E.....2902 Fairfield Ave.

D

Datzman, Richard C.....520 Medical Center Bldg.
Davidoff, Manuel A.....3610 Brooklyn Ave.
Ditton, Irvin Wilson (S).....1214 E. Wayne St.
Duemling, Arnold H...6526 Upper Huntington Rd.
Dunstone, Harry C.....502 Medical Center Bldg.

E

Elston, Lynn W. (S)....604 Medical Center Bldg.
Elston, Ralph W.....604 Medical Center Bldg.
Emenhiser, John L.....1407 Pinehurst Dr.
Engleman, Reinhold.....1301 S. Harrison St.

F

Farquhar, John S. Jr.....3610 Brooklyn Ave.
Ferguson, Arthur N.....2902 Fairfield Ave.
Fichman, Abraham M.....323 W. Berry St.
Flaherty, Robert Anthony....2902 Fairfield Ave.
Franke, Gordon R.....1202 E. State Blvd.
Frankhouser, C. M. A., Jr.
520 Medical Center Bldg.
Fullam, Richard G.....234 Medical Center Bldg.

G

Garton, Harry W.....Hamilton Road, R. R. 6
Gastineau, David C.....520 Medical Center Bldg.
Gentile, Jonathan Paul.....2156 Fairfield Ave.
Gerding, William J.....2638 S. Anthony Blvd.
Giffin, Charles S.....102 Medical Center Bldg.
Gladstone, Naf H.....335 W. Berry St.
Glassley, Stephen H.....1923 E. State Blvd.
Glock, Homer Edwin (S)
324 Medical Center Bldg.
Glock, Maurice E.....229 Medical Center Bldg.
Glock, Wayne R.....2609 Fairfield Ave.
Goebel, Carl W.....327 W. Creighton Ave.
Gould, John C.....2424 Fairfield Ave.
Graham, George M.....1301 S. Harrison St.
Graham, James C.....805 Creighton Ave.
Green, Robert F.....614 W. Berry St.
Greenlee, Robert L.....1110 W. Washington Blvd.
Greist, Walter D.....3024 Fairfield Ave.
Griffith, Harold R.....520 Medical Center Bldg.

H

Hackett, Walter G.....6028 U. Huntington Rd.
Haffner, Herman G.....202 E. Jefferson St.
Haley, Alvin J.....533 W. Washington St.
Hall, William R.....234 Medical Center Bldg.
Haller, Richard C.....3124 E. State Blvd.
Hamilton, Emory D.....234 Medical Center Bldg.
Hamilton, George M.....3124 State Blvd.
Harshman, Louis P. (S).....Veterans Hospital
Hasewinkle, August M.....2828 E. State Blvd.
Hastings, Warren C. 815 Ewing St.
Hattendorf, Anton P.....725 Medical Center Bldg.
Havens, Russell E.....228 Medical Center Bldg.
Hershberger, Philip G.....2609 Fairfield Ave.

Hickman, Donald M.....3408 N. Anthony Blvd.
Hillery, Robert L.....810 W. State Blvd.
Hipskind, Richard E.....332 E. Pontiac St.
Hoffman, Arthur F.....519 Medical Center Bldg.
Holsinger, Robert E.....115 Medical Center Bldg.
Hoover, Joseph R.....3610 Brooklyn Ave.
Howe, Fordyce L.....1525 Oxford St.
Humphreys, John L.....1301 S. Harrison St.

I

Irmscher, George W.....1417 N. Anthony Blvd.
Irmscher, Jane M.....2024 Florida Dr.
Isenogle, Kenneth F.....418 Medical Center Bldg.

J

Jackson, John F.....519 Medical Center Bldg.
Johnston, Richard M.....3318 E. State Blvd.
Jontz, Joe G.....3124 E. State Blvd.
Jontz, Richard L.....520 Medical Center Bldg.
Juergens, Richard B.....1709 Prairie Lane
Jurgensen, Walter T.....3415 Fairfield Ave.

K

Karol, Herbert J.....324 Medical Center Bldg.
Kaufman, Julian R.....3124 E. State Blvd.
Keck, Carleton A.....2902 Fairfield Ave.
Kent, Richard N.....731 Medical Center Bldg.
Keyes, Robert C.....3714 S. Calhoun St.
Kidder, Orva T.....Irene Byron Hospital
Kilgore, Byron.....227 E. Washington Blvd.
Kimbrough, Robert F.....2730 E. State Blvd.
Kleifgen, William A.....446 W. Pontiac St.
Kloepfer, Ronald G.....3124 E. State Blvd.
Klooze, Kenneth W.....3610 Brooklyn
Knight, Lewis W.....3124 E. State Blvd.
Krueger, John E.....204 E. Suttenfield
Kruse, Walter E.....410 McKinnie

L

Ladig, Donald S.....337 E. Berry St.
Laker, Gene C.....2407 Fairoak Dr.
Laker, Richard J.....2407 Fairoak Dr.
Lampe, Elfred H.....2902 Fairfield Ave.
Land, Francis L.....4628 Calhoun
Laycock, Richard M.....6642 St. Joe Rd.
Leming, Ben L.....2902 Fairfield Ave.
Lenk, George G.....1805 E. Washington St.
Lloyd, Robert P.....723 Fulton St.
Logan, Richard S.....3124 E. State Blvd.
Lohman, Robert M.....4017 S. Wayne St.
Lorman, James G.....520 Medical Center Bldg.
Loudermilk, Jack L.....520 Medical Center Bldg.
Lyon, William C.....710 W. Wayne St.

M

McCallister, John W.....3124 E. State Blvd.
McCardle, Edward G.....2201 S. Calhoun St.
McCoy, Roy R.....3701 S. Harrison St.
McDowell, George A.....215 Medical Center Bldg.
McEachern, Cecil G.....2424 Fairfield Ave.
McKeeman, Donald H.....633 W. Wayne St.
Mackel, Frederick O.....2609 Fairfield Ave.
Mann, Richard.....3124 E. State Blvd.
Manning, George C.....534 W. Berry St.
Marsh, Myrle F. 1417 N. Anthony Blvd.
Marshall, Caesar L.....438 E. Lewis St.
Mastrangelo, Michael J...418 Medical Center Bldg.
Mensch, James R.....2120 Forest Park
Mercer, Samuel R.....702 Medical Center Bldg.
Meyer, Herman A.....1030 W. Wayne St.
Meyer, Theodore O.....622 Medical Center Bldg.
Michaelis, Stephen C.....3610 Brooklyn Ave.
Miller, Don E.....2902 Fairfield Ave.
Miller, Edward D.....1402 E. State Blvd.
Miller, H. Paul.....2715 Broadway
Miller, Mahlon F.....222 Medical Center Bldg.
Miller, Orval J.....324 W. Berry St.
Miller, Richard H.....511 W. Wayne St.
Miller, Robert B.....3124 E. State Blvd.
Miller, William J.....2902 Fairfield Ave.
Moats, Carl F.....4007 W. Wayne St.
Moats, George E. (S)....615 E. Washington Blvd.
Moeller, Victor C.....2424 Fairfield Ave.
Moravec, Arthur E.....705 Lincoln Tower
Morey, Edwin E.....2902 S. Fairfield Ave.
Morgan, Milton M.....1147 S. Lafayette St.
Mortenson, Leland J.....3610 Brooklyn Ave.
Mueller, Lawrence W...533 W. Washington Blvd.
Murdock, Harvey L. (S).417 Medical Center Bldg.

N-O

Nill, John H.....204 E. Suttenfield St.
Nolan, Gerald R.....1626 Oxford St.
Oatman, Jack G.....334 Medical Center Bldg.
O'Brian, John F.....1807 E. Washington Blvd.
O'Rourke, Carroll.....604 W. Berry St.

P

Painter, Donald S.....222 Medical Center Bldg.
Parker, Carey B.....1105 S. Harrison St.
Parrot, Donald J.....810 W. State Blvd.
Patterson, Jack W.....717 Broadway
Pauly, Leonard R.....2224 Springfield
Pearson, Huey L.....1801 S. Hanna
Perrin, Kermit F.....2701 S. Anthony Blvd.
Perry, Frederic G.....2902 Fairfield Ave.
Phelps, William J.....2828 E. State Blvd.
Pickett, Merle E.....228 Medical Center Bldg.
Popp, Milton F.....606 Medical Center Bldg.
Powell, M. Jack.....730 W. Berry St.
Priddy, Marvin E.....5010 Riviera Court

Q-R

Rank, William B.....347 W. Berry St.
Reed, John D.....3124 E. State Blvd.
Rissing, Walter J.....229 W. Berry St.
Rockey, Noah A. (S).....1224 E. State Blvd.
Roser, Arthur J.....617 W. Washington Blvd.
Rossiter, Dudley L.....3629 S. Harrison St.
Rothberg, Maurice.....625 W. Berry St.
Rousseau, John W.....3124 E. State Blvd.

S

Sahlmann, Hans.....3418 S. Hanna St.
Salon, Harry W.....535 W. Berry St.
Salon, Joel W.....604 W. Wayne St.
Salon, Nathan L.....604 W. Wayne St.
Sarver, Francis E.....320 Medical Center Bldg.
Savage, Arthur R.....302 W. Berry St.
Schlademan, Karl R.....520 Medical Center Bldg.
Schloss, Robert P.....3504 Quimby Arcade
Schmidt, Eugene E.....228 Medical Center Bldg.
Schmoll, Robert J.....521 W. Wayne St.
Schneider, Louis A.....730 W. Berry St.
Schoen, Frederic L.....5717 S. Anthony Blvd.
Schoenhals, Charles E.....2818 Inwood Drive
Schubert, Jerome C.....2154 Fairfield Ave.
Scoins, William H.....1301 S. Harrison St.
Scott, Harry V.....3718 Knoll Crest Dr.
Scudder, James P.....3124 E. State Blvd.
Senseny, Eugene F.....2902 Fairfield Ave.
Shaw, James E.....3610 Brooklyn Ave.
Shinabery, Lawerence.....1850 Broadway
Short, John T. (S).....2902 Fairfield Ave.
Shugart, Robert R.....2609 Fairfield Ave.
Singer, Elmer C. (S)....310 Medical Center Bldg.
Smith, Philip L.....2902 Fairfield Ave.
Smith, Richard B.....3124 E. State Blvd.
Smith, Roger C.....3124 E. State Blvd.
Snyderman, Sanford C...102 Medical Center Bldg.
Somers, Gerald H.....3610 Brooklyn Ave.
Spencer, C. Herbert....519 Medical Center Bldg.
Stanley, Robert G.....3415 S. Fairfield Ave.
Stauffer, Richard C.....2730 E. State Blvd.
Steigmeyer, David J.....3124 E. State Blvd.
Stier, Paul L.....721 Broadway
Stucky, Jerry L.....5010 Riviera Court
Sullivan, Robert E.....214 Medical Center Bldg.

T

Taylor, Robert G.....2902 Fairfield Ave.
Tennant, David L.....1832 S. Calhoun St.
Terrill, Richard W.....446 W. Pontiac St.
Tomusk, August N.....418 Medical Center Bldg.
Trier, Herbert P.....612 Medical Center Bldg.

U

Ungemach, Willo F.....332 Pontiac

V-W

Vogel, Lloyd A.....519 Medical Center Bldg.
Walker, Floyd B.....3505 S. Monroe
Wallace, Collins R.....234 Medical Center Bldg.
Ward, Gerald F.....3124 E. State Blvd.
Ward, Paula B.....4420 Highwood
Warfield, Chester H.....730 W. Berry St.
Weber, John R.....710 W. Wayne St.
Wick, Alfred A.....731 Medical Center Bldg.
Wierzalis, Edward F.....2017 Sherman St.
Williams, Berniece M.....801 E. State Blvd.
Wilson, Roland B.....1207 S. Lafayette
Worley, Ansel C.....317 Medical Center Bldg.
Wright, William C.....621 Medical Center Bldg.
Wyatt, James L., III.....206 E. Jefferson St.

X-Y-Z

Zehr, Noah (S).....301 W. Creighton
Zweig, Elmer Sam.....344 W. Berry St.

Harvey, Harry C. (S)..Methodist Home, Franklin
Emme, Richard W.....Harlan
Harless, O. Fred.....104 Summit, Monroeville

New Haven

Dahling, Clemens W.....Dahling Bldg.
Dahling, Fred W.....Dahling Bldg.
Emenhiser, Donald C.....608 State Blvd.
Hoetzer, Eldore M.....502 Henry
Sidell, James P.....630 Broadway
Stumpf, Edwin E.....716 Broadway
Wade, Reynolds W.....1018 Bell Ave.

Loudermilk, Richard G. 208 E. Center St., Warsaw
Miller, Kenneth D.....Woodburn

Helmer, Frederic A.
4519 Barbara Pl., Cincinnati, Ohio 45229
Over, John H. 702 12th St., Huntsville, Texas
Philbert, Richard N.
2430 Edity Ave., Redwood City, Calif.
Prentiss, Nelson H...V. A. Hospital, Oteen, N. C.
Schellhouse, Earl M.
V.A. Hospital, Chillicothe, Ohio
Sherwood, Clarence E.
R. R. #2, Box 97A, Madison, S. Dakota
Voorhees, Robert J.
601 S. Brentwood Ave., Clayton, Mo.

BARTHOLOMEW-BROWN COUNTIES

Columbus

Able, Walter.....2760 25th St.
Adler, David L.....Bartholomew County Hospital
Andrews, Fred B.....1919 25th St.
Beggs, Lowell F.....832 Washington St.
Clay, Eleanor.....2739 Central Ave.
Daugherty, Forest D.....2600 Sandcrest Blvd.
Davis, Marvin R.....908 Washington
Dugan, Thomas.....Doctors' Park
Echsner, Herman J.....Doctors' Park
Fisher, Walter S.....422 Ninth St.
Fuller, Robert G.....1919 25th St.
Gammell, Lindley L.....602 22nd St.
Hart, Robert B.....712 Washington St.
Hauersperger, Alfred D.....2760 25th St.
Hawes, Marvin E.....522 Seventh Ave.
Henry, Alvin L.....Doctors' Park
Jacobs, E. Robert.....2760 25th St.
Knotts, Halleck S.....1813 25th St.
Krueger, Robert B.....2739 Central Ave.
McCullough, Henry G...R. R. #4, Old Indpls. Rd.
Macy, George W.....2760 25th St.
Marr, Griffith.....R. R. #1
Mohler, Floyd W.....2739 Central Ave.
Norton, Harold J.....909 Pearl St.
O'Bryan, Richard B.....2739 Central Ave.
Overshiner, Lyman (S).....503 California
Ranck, Benjamin A.....2438 Cottage
Rau, Charles A.....2438 Cottage
Reid, Robert M.....2225 Central Ave.
Richmond, Harold W...Cummins Engine Co., Inc.
Ryan, William J.....Doctors' Park
Schmitt, Richard K.....423 Ninth St.
Sigmund, William B.....2355 Central Ave.
Snapp, Richard A.....2225 Central Ave.
Teal, Dorothy D.....728 Franklin St.
Warshaw, Seymour.....2760 25th St.
Weinland, George C.....R. R. 5, Harrison Lake
Wickstrom, Otto W.....718 Washington St.
Wigh, Russell.....2400 E. 17th St.
Williams, Everett W.....2225 Central Ave.
Zaring, Byron K.....718 Washington St.

Schneider, Kenneth D.....Nashville
Seibel, Robert M.....Nashville

BENTON COUNTY

Taylor, Wade H. (S).....Ambia
Leak, Robert H.....Boswell
Coddens, Avery L.....Earl Park
Altier, William H.....Fowler
Miller, Dan T. (S).....Fowler
Turley, Verne L. (S).....Fowler
McKinney, Donald L.....Otterbein
Schuerich, Virgil.....Oxford
Rutherford, Charles E.
5471 W. 71st St., Indianapolis (68)

BLACKFORD COUNTY

(See Delaware-Blackford)

BOONE COUNTY

Schaaf, Alvin D.....Jamestown

Lebanon

Boyer, Don W.....1125 N. Lebanon St.
Coons, John D. (S)....Boone County Bank Bldg.
Coons, Ritchie.....303 W. Washington St.
Grigsby, Hardin B.....904 Northfield Dr.
Headley, Lloyd M.....1111 N. Lebanon St.
Honan, Paul R.....1720 N. Lebanon St.
Kern, Clarence G.....1720 N. Lebanon St.
Lenox, Jack.....303 W. Washington St.
McAfee, James R.....1005 N. East St
Porter, Jack.....209 W. North St.
Weddle, Charles O.....905 N. Lebanon St.
Wiseheart, Robert H.....905 N. Lebanon St.

Bassett, Margaret A.....Thorntown
Gregg, Edwin E.....Thorntown
Lovett, Harvey D.....Whitestown
Bailey, Lawrence S.....Zionsville
Harvey, Ralph J. (S).....Zionsville

BROWN COUNTY

(See Bartholomew-Brown)

CARROLL COUNTY

Kennedy, Eva N. (S) Camden
Wise, Charles L.....Camden

Delphi

Baker, Eldon E.....109 S. Union St.
Crampton, Charles C. (S).....115 E. Main St.

Petry, T. Neal.....111 E. Franklin St.
Seese, Robert M.....101 W. North St.
Wagoner, George W.....Front & Union Sts.

Adams, Max R.....Flora
McLaughlin, James R.....Flora

CASS COUNTY

Dutchess, C. Toney.....Galveston

Logansport

Adamski, Michael S.....408 North St.
Bailey, Earl W.....212 Fifth St.
Ballard, Charles A. (S).....325½ E. Market St.
Bean, Joseph S.....Memorial Hospital
Burnett, Paul C.....Logansport State Hosp.
Cheng, Sylvia F.....Logansport State Hosp.
Chu, Johnson C.S.....Logansport State Hosp.
Cobb, Clarence M.....Memorial Hospital
Eckert, Russell A.....1101 Michigan Ave.
Fitzgerald, Brice E.....126 Fourth St.
Fogel, Ernest J.....Logansport State Hosp.
Gatzimos, Christos D.....3116 High Street Rd.
Glendening, Richard L.....420-A High St.
Hall, Bernard R.....422 High St.
Harrington, James F.....1001 E. Broadway
Hedde, Eugene L.....211 S. Third St.
Hillis, Lowell J.....718 E. Broadway
Hochhalter, Marian.....86 Ninth St.
Horning, Richard R.....Logansport State Hosp.
Jones, J. Carl.....422 North St.
King, Jay M.....812 North St.
Mackey, Colonel G. (S)..Logansport State Hosp.
Maschmeyer, Robert H.....Logansport State Hosp.
Matheu, Heracleo.....Logansport State Hosp.
Morrical, Russell J.....212 Fifth St.
Parker, E. Camille.....2500 E. Broadway
Parker, Francis W., Jr.....2500 E. Broadway
Pfuetze, Max E.....408 North St.
Phipps, Elwood B.....Logansport State Hosp.
Schenck, Foss (S).....97 - 21st St.
Sheller, Tom G.....Logansport State Hosp.
TerBush, Edward L.....216 Ninth St.
Viney, Charles L.....402 North St.
Wilson, Paul H.....422 North St.
Winter, Donald K.....422 North St.

Newcomb, William K.....Royal Center
Flanagan, Estle P. (S).....Walton
Lybrook, Daniel E. (S).....Young America

CLARK COUNTY

Charlestown

Goodman, Eli.....807 High St.
Jones, David H.....935 Water St.
Marshall, Thomas J. (S).....807 High St.
Shina, Hassi Charlestown Landing Road

Clarksville

Carnes, Edwin R.....647 Eastern Blvd.
Mudd, Joseph P.....815 Eastern Blvd.
Willner, Alan.....630 Eastern Blvd.
Wolverton, George M.....647 Eastern Blvd.

Carr, Joseph H.....Henryville
Greene, William R.....Henryville
Horlander, Fridolin.....Henryville

Jeffersonville

Adair, Samuel L.....201 E. Market St.
Bizer, Mier A.....119 Forest Oak Park
Brill, Joseph B.....201 E. Market St.
Bruner, Ralph W. (S).....437 Spring St.
Buehler, George M.....431 Locust St.
Byrd, Ryland P.....210 Sparks Ave.
Carlberg, Dale L.....226 E. Maple St.
Carney, Joel T. (S).....347 Spring St.
Clark, William B., Jr.....435 Spring St.
Corrao, Thomas J.....435 Spring St.
Dare, Lee A.....209 E. Maple St.
Ely, Cecil W.....Clark County Hospital
Forsee, Norman E.....211 E. Market St.
Hargett, Herbert P.....435 Spring St.
Havens, A. Lyle.....432 Wall St.
Havens, Thomas R.....432 Wall St.
Huoni, John S...1405 Youngstown Shopping Center
Isler, Nathaniel C.....519 Spring St.
Johnson, Jerome M.....1426 Gateway Plaza
McKechnie, Robert K.....432 Wall St.
Oca, Clemente F.....437 Spring St.
Reed, Edsel S.....Clark County Hospital
Reeder, Henry H.....140 N. High St.
Roby, Alma L.....201 E. Market St.
Shaw, Houston W.....435 Spring St.
Weems, Mallory P.....203 Lindley Bldg.
Witt, William R.....Medical Center

Sellersburg

Regan, George L.....115 N. Indiana Ave.
Sturgis, Donald G.....Box 156

Baldwin, J. H. (S)
1632 Spruce St., Apt., Philadelphia, Pa. 19103

CLAY COUNTY

Brazil

Farid, Rahim S.....111 N. Walnut St.
Garvin, Donald B.....111 N. Walnut St.
McCormick, Wilbur C.....R. R. #2
Maurer, J. Frank.....111 N. Walnut St.
Maurer, Robert M.....111 N. Walnut St.
Mehne, Richard G.....1½ E. National Ave.
Shattuck, John C.....1½ E. National Ave.
Webster, Robert K.....28 N. Franklin St.
Wood, Opal L.....111 N. Walnut St.

Moon, Charles E.....Center Point
Bond, Walter C.....Clay City
Buell, Forrest R.....Clay City

CLINTON COUNTY

Frankfort

Applegate, Albert E.....1303 S. Jackson St.
Beardsley, Frank A. Jr.....400 Kentwood Dr.
Carrel, Francis E.....209 S. Columbia St.
Dykhuizen, Theodore A.....201 W. Walnut St.
Erdel, Milton W.....2 E. White St.
Flora, Fred W.....1256 S. Jackson St.
Hammersley, George K.....361 E. Clinton St.
Hedgcock, Robert A.....259 E. Clinton St.
Stout, Harry T.....1256 S. Jackson St.
Van Kirk, Paul P.....1252 S. Jackson St.
Williams, Earl K.....Clinton County Hospital
Work, Bruce A.....306 Peoples Life Bldg.

Bush, Charles E.....Kirklin
Carlyle, Ivan E. (S).....Michigantown
Ketcham, John S. (S).....Rossville
Weller, Ralph D.....Rossville

Work, Bruce A., Jr.
1406 White St., Ann Arbor, Mich.
Holmes, Claude D. (S)
329 Romano St., Coral Gables, Fla.

CRAWFORD COUNTY

(See Harrison-Crawford)

DAVIESS-MARTIN COUNTIES

Rohrer, James R.....Elnora

Loogootee

Chattin, Robert E.....102 Wood
Lett, Emory B.....408 E. Main

Sears, Don.....Odon

Washington

Barrett, James W. 1312 Bedford Rd.
Blazey, Arthur G.....7 E. Walnut St.
Chattin, Vance J.....514 E. Main St.
Farris, John J.....514 E. Main St.
Fox, C. Philip.....305 Peoples Bank Bldg.
Lindsay, Hamlin B.....511 E. Main St.
McKittrick, Jack.....Peoples Bank Bldg.
McNaughton, Lawrence M.....400 E. Hefron St.
Norton, Horace O.....511 E. Hefron St.
Rang, Arthur A. (S).....211 N.E. Ninth St.
Rang, Robert H.....1312 Bedford Rd.
Ross, Glenn E.....1307 Bedford Rd.
Schafer, William C.....1312 Bedford Rd.
Schroeder, Henry R., Jr.....101 N.E. First St.
Seat, Marshall H.....2 E. Walnut St.

DEARBORN-OHIO COUNTIES

Aurora

Baker, Leslie M.....501 Fourth St.
Gresham, Edwin L.....501 Fourth St.
Jackson, John K.....223 Mechanic St.
Olcott, Charles W.....203 Main St.
Treon, James F. (S).....505 Fifth St.

McNeely, Matthew J.....Box 35, Dillsboro

Lawrenceburg

Bowen, Gerald T.....209 Fourth St.
Conrad, Henry W.....370 Bielby Rd.
Frable, Frank L., Jr.....370 Bielby Rd.
Houston, Fred D.....30 W. High St.
Hunter, Lowell G.....370 Bielby Rd.
Lindgren, Ivan T.....370 Bielby Rd.
Morrison, George G., Jr.....209 Fourth Ave.
Pfeifer, James M.....319 Front St.
Rhodes, Alfred K.....370 Bielby Rd.
Stahl, Norman L.....370 Bielby Rd.
Streck, Francis A.....326 Walnut St.
Weisenberger, Brockton L.....370 Bielby Rd.

Fessler, Gordon S.....311 Main St., Rising Sun
Mauricio, Amado S. A. ...226 Main St., Rising Sun

DECATUR COUNTY

Tremain, Milton A. (S).....Adams

Greensburg

Acher, Robert P.....221 E. Washington St.
Callaghan, Winship C.....304 Bates Bldg.
Dickson, Dale D.....333 E. First St.
Miller, James C.....205 Bates Bldg.
Morrison, James T.....207 N. Franklin St.
Overpeck, Charles.....Murphy Bldg.
Shaffer, William.....214 N. Franklin St.
Walker, Louis.....215 N. Franklin St.

Porter, Robert A.
8211 Anentone Lane, Indianapolis (19)
Porter, Edward A. (S).....Westport

DE KALB COUNTY

Showalter, John P.....R. R. 5, Angola

Auburn

Covell, Harry M.....127 W. Seventh St.
Geisinger, Lewis N. (S).....805 S. Indiana Ave.
Harvey, John C.....405 S. Main St.
Hines, Archie V. (S).....401 S. Main St.
Hines, John H.....403 Main St.
Hippensteel, Harland V.....208 W. Seventh St.
Nugen, Harold.....223 W. Seventh St.
Rogers, Evered E.....212 W. Sixth St.
Sanders, Jesse A. (S).....1007 S. Main St.
Souder, Bonnell M. (S).....206 W. Seventh St.
Wills, Max.....347 W. Seventh St.

Shultz, Clifford.....Butler
Weirich, Charles I.....Butler

Garrett

Carpenter, Ramesh S.....514 S. Randolph St.
Jinnings, Loren E.....200 S. Randolph St.
Kantzer, Floyd B.....200 S. Randolph St.
Nason, Robert A.....123 E. King St.
Novy, Charles A.....200 S. Randolph St.

Coleman, Floyd B.....Waterloo

DELAWARE-BLACKFORD COUNTIES

Brown, Stewart D.....Albany
Puterbaugh, Karl E.....Albany
Gray, William J.....428 W. Ninth St., Anderson
Hurley, John R.....Daleville
Ko, Richard C. B.....Gaston

Hartford City

Dodds, James U.....227 W. Main St.
Dudgeon, Charles A.....720 N. Spring St.
Jackson, Dean B.....401 W. Washington St.
Owsley, Guy A.....214 N. High St.
Parks, George O.....720 N. Spring St.
Weldy, Bryce P.....227 W. Franklin St.
Werry, Leslie E. (S).....218 W. Washington St.

Doles, Ted S.....613 N. 10th St. Middletown
Egger, Ross L.....613 N. 10th St., Middletown
Burns, Paul E.....119 W. High St., Montpelier
Ingram, Richard
124 S. Washington St., Montpelier

Muncie

Adams, Julia L.....Ball State Teacher's College
Adams, William B.....Ball Memorial Hospital
Alvey, Charles R.....217 S. Cherry St.
Ball, Clay A. (S).....303 W. Adams St.
Ball, Philip.....2600 W. Jackson St.
Benken, Lawrence D.....321 University Ave.
Bergwall, Warren L.....223 Tillotson Ave.
Bibler, Henry E.....311 W. Adams St.
Botkin, Charles L. (S).....508 W. Jackson St.
Botkin, Charles T.....400 White River Blvd.
Botkin, Clyde G.....508 W. Jackson St.
Brown, Leland G.....412 White River Blvd.
Brown, Thomas M.....212 N. Pauline Ave.
Burwell, Stanley W.....424 W. Jackson St.
Butterfield, Robert M.....315 W. Jackson St.
Butz, Ralph O.....1525 W. Jackson St.
Clark, Robert M.....321 University Ave.
Clouse, John F.....Ball Memorial Hosp.
Cochran, Robert B.....1111 W. Jackson St.
Collins, Margaret C.....Ball Memorial Hospital
Cooper, John F.....3022 S. Madison
Covalt, Wendell E.....2724 W. North St.
Cullison, John L.....2724 W. North St.
Cure, Elmer T.....122 W. Jackson St.
David, George J.....2200 Janney Ave.
Davis, Edgar C. (S) 203 Western Reserve Bldg.
Deutsch, William.....406 White River Blvd.
Dietz, David J.....100 Western Reserve Bldg.
Dunning, Thomas W.....400½ White River Blvd.
Dutchman, William R.....Ball Memorial Hospital
Fiederlein, Frederick J.....808 W. Jackson St.
Galliher, Marjorie J.....410 White River Blvd.
Garling, Luvern C.....521 S. Tillotson Ave.
Geckler, Charles E.....203 Western Reserve Bldg.
Gibson, Robert K.....806 W. Jackson St.
Gill, Thomas A.....808 W. Jackson St.

Greiber, Marvin F.....420 W. Washington St.
Gustafson, Milton H.....808 W. Jackson St.
Hall, Robert S.....514 Wysor Bldg.
Harvey, Emerson C., Jr.
Delco Battery Operations
Hayes, Theodore R.....210 S. High St.
Henderson, Ramon A.....806 W. Jackson St.
High, Ralph L.....420 W. Washington St.
Holmes, John L.....412 White River Blvd.
Hostetter, Irwin S.....115 N. Cherry St.
Imhof, Joseph D.....318 W. Adams St.
Judd, Donald R.....100 N. Cherry St.
Kalker, Morton.....Ball Memorial Hospital
Kammer, Grace C.....1005 W. Parkway Dr.
Kammer, Walter F.....420 W. Washington St.
Kim, Joon S.....Ball Memorial Hospital
Kirshman, Forrest E.....211 S. High St.
Koch, Edwin F., Jr.....Ball Memorial Hospital
Koss, K. William.....1600 W. Jackson St.
Kress, James W.....323 University Ave.
LaDuron, Jules F. (S).....614 S. Liberty St.
McCallister, Larry L.....2518 Rosewood
McClintock, James A.....316 W. Adams St.
McDowell, Fletcher W.....926 W. Main St.
Mathewson, Russell C.....553 Johnson Bldg.
Montgomery, Lall G.....Ball Memorial Hospital
Moore, Jack C.....412 White River Blvd.
Moore, Thomas C.....110 N. Cherry St.
Moore, William C. (S).....110 N. Cherry St.
Morris, Jean W.....247 Johnson Bldg.
Neece, Gus W.....Ball State Teacher's College
Nelson, Harold E.....424 W. Jackson St.
Osborne, John V.....420 W. Washington St.
Peacock, Robert C.....2724 W. North St.
Pippenger, Joseph I.....310 W. Jackson St.
Pippenger, Wayne G...Ball State Teacher's College
Quick, William J.....314 E. Washington St.
Rivers, Glynn A.....625 W. Adams St.
Schulhof, Maurice G.....420 W. Washington St.
Smith, James S.....501 Kirby Ave.
Speck, Carlson R.....Ball Memorial Hospital
Steele, Frank M.....420 W. Washington St.
Stibbins, Warren E.....2605 Wheeling Ave.
Stout, Francis E.....2423 W. Jackson St.
Stump, Richard L.....2000 S. Madison
Swanson, Roy A.....Ball State Teacher's College
Taylor, Donald R.....Ball Memorial Hospital
Tharp, Donald W.....1517 N. Tillotson Ave.
Tomlin, Hugh M.....420 W. Washington St.
Venis, Kemper N.....108 N. Liberty St.
Vlaskamp, Elaine M.....401 W. Main St.
Voss, Gert.....420 W. Washington St.
Walker, Jack M.....412 White River Blvd.
Ware, Herbert E.....2200 Janney Ave.
Weisner, Richard M.....Ball Memorial Hosp.
Young, Gerald S.....924 W. Main St.

Hinchman, Jean F.....Parker
Hill, Robert E.....Yorktown
Moss, Mavor J.....Yorktown

Morse, Arthur S.
6341 64th Ave., East Riverdale, Md.

DUBOIS COUNTY

Barrow, John H.....Dale
Backer, Henry G.....Ferdinand
Erhart, Hubert.....Ferdinand
Bland, Jack D.....Holland

Huntingburg

Amini, Sohrab.....521 Fourth St.
Bretz, John M.....302 Fourth St.
Craig, Harry L.....409 Van Buren
Scales, Alfred B.....407 Van Buren
Scales, Allen D.....409 Van Buren
Stork, Harvey K.....530 Fourth St.
Williams, Fielding P.....215 W. Walnut St.

Jasper

Beaven, John B.....111 Central Bldg.
Benages, Anthony.....948 MacArthur St.
Gootee, Francis H.....501 Clay St.
Gootee, Thomas H.....501 Clay St.
Heck, Martin C.....801 Newton
Held, George A.....716 W. Ninth St.
Klamer, Charles H.....715 MacArthur St.
Lukemeyer, St. John.....109 W. 12th St.
Ploetner, Edward J.....201 W. Sixth St.
Salb, John P.....106 Metzger Bldg.
Salb, Leo A. (S).....301 E. Sixth St.
Wagner, Arthur L.....115 E. Ninth St.

Ozalan, Necmettin H.....St. Meinrad

ELKHART COUNTY

Horswell, Richard G.....Bristol
Neidballa, Edward G.....Bristol

Elkhart

Arlook, Theodore D.....912 Franklin St.
Atwood, William H.....405 S. Second St.
Bender, Robert L.....411 S. Third St.
Benson, James E.....405 S. Second St.
Billings, Elmer R.....405 S. Second St.
Bloom, George R.....506 S. Second St.
Boling, Richard C.....214 W. Marion St.
Bowdoin, George E. (S).....515 S. Second St.
Campbell, Patrick B.....605 Oakland Ave.
Classen, Pete R. C.....4112 S. Main St.
Compton, Walter A.....2225 Greenleaf Blvd.
Conklin, Raymond L...Miles-Ames Research Labs.
Cormican, Herbert L.....1400 Hudson St.
Dovey, Edward G.....513 Oakland Ave.
Durham, Thomas E.....405 S. Second St.
Echeverria, Rodolfo E.....405 S. Second St.
Elliott, Thomas A.....405 S. Second St.
Finfrock, James D.....608 West Blvd.
Fleming, Claude F. (S).....217 W. Jefferson St.
Futterknecht, James O.....405 S. Second St.
Gattman, George B.....405 S. Second St.
Graber, Virgil R.....1400 Hudson St.
Gray, Edwin H.....518 W. Franklin St.
Gray, Mary Case.....518 W. Franklin St.
Hannah, Jack W.....1906 E. Jackson Blvd.
Heminway, Norman L.
Miles-Ames Research Labs.
Hurley, James W.....405 S. Second St.
Ivy, John H.....405 S. Second St.
Jones, Robert B.....1528 W. Franklin St.
Keating, John U.....224 W. High St.
Kesim, Mufit H.....317 W. Lusher Ave.
Kintner, Burton E.....506 S. Second St.
Kistner, Arthur W.....400 Equity Bldg.
Klassen, Otto D.....2600 Oakland Ave.
Koehler, Elmer G.....416 W. Lexington Ave.
Krause, Friedrich.....4117 S. Main St.
Lundt, Milo O.....521 S. Second St.
Luther, William C.....Ames Company, Inc.
McArt, Bruce A.....221 W. Jefferson
Mark, George A.....413 W. Franklin St.
Martin, Paul H.....313 N. Second St.
Middleton, Ramona J.....1400 Hudson St.
Miller, Donald G.....4634 W. Indiana Ave.
Miller, Galen R.....403 S. Ninth St.
Miller, Hugh A.....Ames Company, Inc.
Miller, Samuel T. (S).....506 S. Second St.
Mininger, Edward P.....1400 Hudson St.
Mishkin, Irving.....209 S. Second St.
Norris, Allen A. (S).....401 W. Marion St.
Paff, William A.....115 S. Third St.
Paine, George E.....329 Meisner Ave.
Pancost, Vernon K.....1000 W. Marion St.
Parshall, Dale B.....3528 Gordon Rd.

Pletcher, William D.....405 S. Second St.
Rouen, Robert L.....114 Monger Bldg.
Rupe, Lloyd O.....211 S. Fifth St.
Rupel, Dennis F.....2600 Oakland Ave.
Schlosser, Herbert C.....116 W. Marion St.
Sears, Murray M. (S).....304 Equity Bldg.
Silber, David L., Jr.....405 S. Second St.
Sobol, Z. W.....433 East Blvd.
Spray, Page E.....320 W. High St.
Stauffer, Walter A. (S).....701 Strong Ave.
Stubbins, William M.....412 S. Second St.
Swank, Lucretia R.....1600 E. Jackson Blvd.
Swihart, Danny D.....506 S. Second St.
Swihart, Homer R.....1200 W. Marion St.
Wilson, Orley E.....217 N. Main St.
Work, James A., Jr., (S).....406 S. Second St.
Yoder, C. Richard.....603 Oakland Ave.

Goshen

Bender, John M.....112 W. High Park Ave.
Bigler, Frederick W.....214 S. Fifth St.
Bosler, Howard A.....214 Waterford Rd.
Bowser, Philip G.....107 S. Fifth St.
Chandler, Leon H.....112 E. Lincoln Ave.
Harris, Neil R.....307 S. Seventh St.
Hostetler, Carl M.....304 E. Lincoln Ave.
Kaufman, Lillie S.....901 Mervin Ave.
Kennedy, Myron S.....314 S. Fifth St.
Krabill, Willard S.....112 W. High Park Ave.
Martin, Floyd S.....127 E. Lincoln St.
Quilty, Thomas J.....112 E. Madison St.
Simmons, Lloyd H. (S).....208 E. Lincoln Ave.
Smucker, Ernest E.....112 S. Fifth St.
Troyer, Dana O.....122 E. Clinton St.
Troyer, George W.....110 W. High Park Ave.
Turner, John P.....115 E. Washington St.
Wagner, David G.....307 S. Seventh St.
Westfall, George S.....214 E. Lincoln St.
Young, Ralph H.....113 E. Madison St.

Teters, Melvin S. (S).....Middlebury
Yoder, Jonathan G.....Middlebury
Rheinheimer, Floyd L.....Milford
Massanari, Walter S.....Millersburg

Nappanee

Kendall, Forest M.....252 W. Market St.
Price, Douglas W.....162 E. Market St.
Roose, Lisle W.....357 N. Nappanee St.
Wenger, James E.....357 N. Nappanee St.

DeFries, John J.....New Paris

Clark, Jack P.....303 S. Hunnington, Syracuse
Craig, Robert A.....P. O. Box 607, Syracuse
Fosbrink, Ephraim L...107 W. Main St., Syracuse
Zimmerman, William H.....R. R. No. 2, Syracuse

Guttman, John B.....Wakarusa
Miller, James.....Wakarusa
Mendez, Carlos. Beatty Memorial Hosp., Westville

Todd, David D. (S)
5835 Beaumont Ave., La Jolla, Calif.

FAYETTE-FRANKLIN COUNTIES

Brookville

Foreman, Walter A.....617 Main St.
Peters, Elmer E.....830 Main St.
Seal, Perry F.....901 Main St.
Smith, Herbert N.....812 Main St.

Connersville

Dale, Maxwell H.....818 Grand Ave.
Ellis, George M.....108 E. 10th St.
Gregg, Albert F.....124 E. Sixth St.
Hudson, Arlington M.....321 W. 20th
Kerrigan, William F.....718 Central Ave.
Lockhart, Jack M.....707 W. Third St.
Mountain, Francis B.....930 Central Ave.
Neukamp, Frank H.....707 W. Third St.
Sanders, Bertram W.....930 Central Ave.
Steinem, Joseph L.....812 Grand Ave.
Watterson, Gerald T.....1910 Virginia Ave.
Winklepleck, A. M.....R. R. #6

Poston, Clement L.....R. R. 2, Laurel

FLOYD COUNTY

New Albany

Baker, Avey M. (S).....811 E. Spring St.
Baxter, Samuel M.....1201 E. Spring St.
Bickers, Everett E.....3541 Paoli Pike
Brown, Kenneth H.....410 E. Spring St.
Buchman, Marshall H.....1824 State St.
Cannon, Daniel H.....1203 E. Spring St.
Cook, Melvin D.....919 E. Spring St.
Edwards, William F.....604 E. Spring St.
Garner, William H., Jr.....919 E. Spring St.
Garner, William H., Sr.....919 E. Spring St.
Gentile, John P.....101 Adams St.
Geyer, Joseph H.....Southern Indiana Tuberculosis Hosp.
Harris, Robert W.....2652 Charlestown Rd.
Hauss, Augustus P. (S).....117 E. Spring St.
Hess, Paul P.....Floyd Co. Bank Bldg.
Higgins, John R.....700 E. Spring St.
LaFollette, Donald R.....1000 E. Spring St.
LaFollette, Robert E.....1000 E. Spring St.
McCullough, James Y.....700 E. Spring St.
Nedelkoff, Bogdan.....R. R. No. 2, Box 500H
Paris, John M.....602 E. Spring St.
Pierce, Gene S.....1696 Garretson Lane
Robertson, Addis N. (S).....820 E. Spring St.
Robinson, Nan.....1726 State St.
Ruoff, William F.....1109 Lafayette Dr.
Shelton, Clyde F.....1726 State St.
Sloan, Herbert P.....1207 E. Spring St.
Sonne, Irvin H., Jr.....1850 State St.
Streepey, Jefferson I.....1102 E. Spring St.
Tyler, Frank T. (S).....Hausfeldt Lane
Voyles, Harry E.....213 Elsby Bldg.
Wallace, Elmer L.....1516 State St.
Wolfe, Morton F.....2533 Glenwood Ct.
Wolfe, Nelson A.....1117 E. Spring St.
Worley, Henry L.....1104 E. Spring St.

Youngs, Paul E.....Georgetown
Byrn, Howard W. (S).....Oxford

FOUNTAIN-WARREN COUNTIES

Attica

Fisher, John E.....217 S. Perry St.
Maris, Lee J.....201 Brady St.
Petrich, Peter R.....401 S. Perry St.
Raymundo, Vivencio F.....401 S. Perry St.

Covington

Hoffman, Max N.....416 Union St.
Humphrey, Edward M.....Olin Mathieson Corp.
Stephens, Lowell R.....600 E. Liberty St.
Suzuki, Tsutomu T.....505 Washington St.

Furr, Jack D.....Kingman
Smith, Byron J.....Kingman
Person, Theodore C.....Veedersburg
Rusk, Hubert M.....Wallace
Nelson, Carl A.....West Lebanon
Crain, James W.....Williamsport

FULTON COUNTY

Herrick, Charles L.....Akron
Miller, Virgil C.....Akron
Dielman, Franklin C. (S).....Fulton
Kraning, Kenneth K.....Kewanna

Rochester

Herendeen, Elbie V.....120 W. Ninth St.
Knockle, Wayne L.....819 E. Ninth St.
Richardson, Charles L.....121 W. Eighth St.
Richardson, Joseph D.....121 W. Eighth St.
Rowe, Howard H.....720 Jefferson St.
Rusler, William J.....817 E. Ninth St.
Stinson, Dean K.....816 Main St.

Kelsey, Lawrence E.....102 W. Keim Dr., Phoenix, Ariz.

GIBSON COUNTY

Geick, Raymond G.....Fort Branch
Marchand, Edwin V.....Haubstadt
Petitjean, Harold G.....Haubstadt
Dye, William E.....Oakland City
Ropp, Eldon R. (S).....Oakland City

Princeton

Carpentier, Harry F.....105 E. Broadway
Folck, John K.....115 N. Prince St.
Graves, Orville M. (S).....116 S. Hart St.
McCarty, Virgil.....113 S. Main St.
McElroy, Robert S.....116 S. Main St.
Peck, James F.....218 Broadway
Weitzel, Roland E.....114 S. Hart St.
Wells, William R.....109 E. State St.

Brazelton, O. T. (S)
13601 Cedar Crest Lane #100-G, Seal Beach, Calif.

GRANT COUNTY

Breedlove, C. Dane.....Fairmount
Henley, Glenn (S).....Fairmount
Yale, Charles A.....Fairmount
Garrison, Leon J..... 114 S. First St., Gas City
Koontz, William A.....126 E. Main St., Gas City
Shoemaker, Richard L.
211 E. South "A" St., Gas City
Rhamy, Donald 8448 Spring Mill Ct., Indianapolis
Baskett, Russell J.....Jonesboro

Marion

Abell, Charles F., Jr.....500 Wabash Ave.
Abell, Charles F.....500 Wabash Ave.
Alderfer, Henry H.....131 N. Washington St.
Ansbacher, Stefan (H).....Fox Station Rd. W.
Ayres, Wendell W.....500 Wabash Ave.
Bailey, Douglas A.....107 E. 31st St.
Bloom, Asa W.....724 W. Third St.
Boyer, Grace B..... 605 Locust St.
Brown, Robert M....520 Marion Nat'l Bank Bldg.
Comeau, William J.....Marion General Hosp.
Cunningham, Robert D.....500 Wabash Ave.
Daniels, George R. (S).....106 N. E Srteet
Davis, Joseph B.....131 N. Washington St.
Davis, Merrill S. (S).....131 N. Washington St.
Davis, Richard M.....131 N. Washington St.
Donaldson, Miles.....2927 S. Washington St.
Dunbar, Fred E.....232 S. Miller Ave.
Fisher, Henry.....1502 S. Washington St.
Fuelling, James L.....131 N. Washington St.
Ganz, Max.....930 S. Adams St.
Goldsmith, David A.....Veterans Hospital
Grant, M. Arthur.....P. O. Box 989
Hover, Galen M.....Veterans Hospital
Hummel, Russel M.....500 Wabash Ave.
Jarrett, John C.....131 N. Washington St.
Lahr, Richard E.....1121 W. Third St.
Langrall, Harrison M., Jr...131 N. Washington St.
Larzelere, Henry B.....131 N. Washington St.
Lavengood, Russell W.....225 Glass Block
Long, Max R.....803 S. Boots St.
Lonngren, Dudley H.....131 N. Washington St.
Love, V. Logan.....131 N. Washington St.
Miller, H. Allison.....320 Glass Block
Pattison, John D.....131 N. Washington St.
Pearcy, Marcene.....500 Wabash Ave.
Powell, J. Paxton.....500 Wabash Ave.
Price, Ambrose M.....219 E. 30th St.
Reid, James D.....505 Buckingham Dr.
Renbarger, Lester L.....1531 W. Second
Rhamy, Arthur P.....500 Wabash Ave.
Rhorer, John G.....500 Wabash Ave.
Richardson, Joseph H.....131 N. Washington St.
Schroeder, Robert W.....317 N. Western Ave.
Simmons, Frederick H.....1009 N. Baldwin
Skomp, Claud E.....500 Wabash Ave.
Smith, Barton T.....131 N. Washington St.
Snowhite, Arthur B.....500 Wabash Ave.
Thompson, B. Jay.....Marion General Hosp.
Thompson, John R.....930 S. Adams St.
Walton, R. Lee.....131 N. Washington St.
Warren, Carroll B.....511 Glass Block
Weinberg, Samuel.....104 W. Third St.
Wilson, Ned A.....317 N. Western Ave.
Wojcik, Ladislas D.....131 N. Washington St.
Woodbury, John W.....131 N. Washington St.
Young, Robert G.....2927 S. Washington St.

Beck, Thomas A.....Swayzee
Taylor, Everett C.....Upland
Rifner, Eugene S.....Van Buren
McIlwain, Eleanor E....Methodist Home, Warren
McIlwain, Robert E. Methodist Home, Warren
Matter, Milton, Jr.....In Air Force

GREENE COUNTY

Bloomfield

Graf, Jerome A.....6 E. Main St.
Mount, Mathias S.....55 N. Franklin St.
Turner, Harold B. (S).....126 E. Indiana Ave.
Turner, Jack J.....126 E. Indiana Ave.
Van Sandt, Frank A. (S).....110½ E. Main St.

Jasonville

Porter, Carl M.....124 Cook St.
Rotman, Harry G.....111½ E. Main St.
Rotman, Sam I.....P. O. Box 127

Linton

Bailey, Edwin B.....129 E. Vincennes
Broshears, Kenneth P.....129 E. Vincennes
Raney, Ben B.....129 E. Vincennes
Tomak, Milton E.....289 N. Main St.
Woner, John W.....Linton

Hamilton, M. Luther (S).....Newberry
Moses, George E.....Worthington
Moses, Robert E.....Worthington

HAMILTON COUNTY

Karlick, Joseph R.....Arcadia
McDaniel, Franklin P. (S).....Atlanta
Donahue, Claude M.....Carmel
Thomas, W. Clayton.....Carmel
Havens, Oscar.....Cicero

Noblesville

Ambrose, Jesse C.....298 N. Ninth Street
Blackburn, Howard R.....Riverview Hospital
Campbell, Sam W.....88 S. 19th St.
Carter, Eunice M.....1084 Clinton St.
Harris, Robert F.....120 N. Ninth St.

Hash, John S.....110 Lakeview
Haywood, John G.....120 N. 11th St.
Hooke, Samuel W. (S).....P. O. Box 224
Kraft, Haldon.....195 S. 10th St.
Lanning, R. Adrian.....10th and North Dr.
Lloyd, Joe R.....107 John St.
Shanks, Ray W.....104 S. 10th St.
Southard, Carl B.....55 S. 16th St.

Griffith, James W.....Sheridan
Manhart, Doyle B.....Sheridan
Newby, Eugene Sheridan
Waitt, Paul.....Sheridan
Connoy, Andrew F.....Westfield
Connoy, Leo F.....Westfield

HANCOCK COUNTY

Scott, Robert O.....Charlottesville
Garrison, James L.....Cumberland
Navin, Hugh K.....Fortville
Rhynearson, Hal R..... Fortville

Greenfield

Beeson, Wilbur P.....1001 N. State St.
Endicott, Wayne H. 10 W. Boyd St.
Farrell, John J., Jr.....1001 N. State St.
Henn, R. Anthony.....137 Michigan St.
Hunter, Donn R.....10 W. Boyd St.
Kinneman, Robert E.....114 N. State St.
Kirby, Ted C.....1001 N. State St.
Smith, John H.....114 N. State St.
Vingis, Bronie A.....746 N. State St.
Woods, James R., Jr.....11 N. State St.

Cagle, Bob R.....New Palestine
Pierson, Thomas A.....New Palestine
Freeborn, Warren S., Jr.....Oaklandon
Miller, Joseph A.....Oaklandon
Gibbs, Charles M. (S)..Methodist Home, Warren
Kuhn, Robert W.....Wilkinson

HARRISON-CRAWFORD COUNTIES

Corydon

Blessinger, Louis H.....101 W. Chestnut St.
Brockman, Wilfred J.....439 E. Chestnut
Dillman, Carl E.....Beaver & Oak Sts.
Dukes, David J.....439 E. Chestnut St.
Jordan, Richard A.....Harrison Dr.
Martin, Samuel W.....R.R. 1

Baker, Guy D. (S).....Crandall
Gobbel, Novy E. (S).....English
Seipel, Stanley.....Lanesville
Benz, Jesse C. (S).....Marengo
Lynch, Otis R.....Marengo

Mathys, Alfred (S).....234 E. Walnut St., Louisville, Ky.

HENDRICKS COUNTY

Brownsburg

Black, M. James.....702 E. Main St.
Foltz, Lloyd E.....20 W. Main St.
Scudder, Arthur N.....24 N. Grant St.
Walker, Thomas M.....702 E. Main St.

Danville

Cheesman, Donald D.....637 E. Main St.
Franz, Mount E.
% Fred Shelton, Danville State Bank
Heinlein, Carl L.....637 E. Main St.
Kirtley, Robert W.....138 W. Marion St.
Koch, Elmer L.....201 E. Columbia St.
Terry, Lloyd S.....138 W. Marion St.
Chase, Thomas P.
Avon, Box 300C, R. R. 8, Indianapolis
Roller, Mac C.
Avon, Box 300C, R. R. 8, Indianapolis
Ellis, Lyman H.....Lizton
Gibbs, Joseph W.
Home Lawn Sanitarium, Martinsville
Karpel, Bernard.....Mooresville
Wiseheart, Oscar H. (S).....North Salem
Scamahorn, Malcolm O.....Pittsboro

Plainfield

Aiken, Milo M.....140 N. Center St.
Cohen, Irving.....645 E. Main St.
Haggard, David B.....P. O. Box 191
Stafford, William C.....107 W. Main St.
Warbinton, Fred P.....P. O. Box 191

HENRY COUNTY

Clark, Marion E.....Cambridge City
Donahue, Francis E.....Dublin
Hollenberg, Alfred E.
700 N. Washington St., Hagerstown
Miller, William A..99 S. Washington, Hagerstown
Wiatt, Leonard H.....Knightstown
Scheetz, Marion R.....Lewisville
Stauffer, George E.....Mooreland

New Castle

Amos, Robert L.....924 Lincoln Ave.
Balcom, Francis H.....2003 Wuthering Dr.
Bledsoe, James G.....319 S. 14th St.
Brock, Joseph T.....New Castle State Hosp.
Burnett, Arthur B.....106 N. Main St.
Cain, David R.....New Castle State Hosp.
Craig, Alexander F.....415 Raintree Dr.
Das, Amal K.....New Castle State Hosp.
Dye, Cloyd L.....1319 Church St.
Easter, James N.....1912 Bundy Ave.
Fisher, John E.....540 S. Main St.
Foster, Ray T.....420 N. Main St.
Grant, Phyllis A.....1912 Bundy Ave.
Harrison, Benjamin L.....540 S. Main St.
Heilman, William C. (S).....1319 Church St.
Heilman, William C., Jr.,.....1319 Church St.
Hill, Kenneth G.....1319 Church St.
Iterman, George E. (S).....1319 Church St.
Kennedy, Walter U. (S).....208 Union Block
Life, Homer L.....1015 Broad St.
McClelland, Harry N.....410 Burr Bldg.
McDonald, Frank C.....527 S. Main St.
McElroy, James S.....1319 Church St.
McKee, Roy G.....606 N. Fair Oaks Dr.
Murray, William E.....New Castle State Hosp.
Saint, William K.....540 "B"South Main St.
Smith, Mark E.....1319 Church St.
Steussy, Calvin N.....Henry Co. Hospital
Stricker, Paul J.....319 S. 14th St.
Thorne, Charles E.....200 N. 12th St.
Vivian, Donald E.....Henry County Hospital
Wilhelm, Guido P.....1319 Church St.

Robertson, William S.....Spiceland

HOWARD COUNTY

Denton, Larkin D.....Greentown
Shoup, Homer B. (S).....Greentown

Kokomo

Althoff, William R.....Chrysler Corporation
Alward, John H.....321 W. Walnut St.
Artis, Myrle E.....107½ S. Union St.
Ault, Carl H.....502 S. Berkley Rd.
Belding, Ray T.....406 Southway Blvd., East
Blaisdell, Glenn D..... Delco Radio Div.
Boughman, Joe D.....2008 W. Sycamore
Bowers, Copeland C.....210 W. Mulberry St.

Bowers, Garvey B.....210 W. Mulberry St.
Bowers, John A.....210 W. Mulberry St.
Bradley, Richard V.....2804 S. Washington
Brown, Earl R., Jr.....1907 W. Sycamore St.
Bruegge, Theodore J.....315 S. Berkley Rd.
Cattell, Lee M.....214 E. Mulberry St.
Clarke, Elton R. (S).....4320 W. Sycamore Lane
Conley, Thomas M.....500 Southway Blvd., East
Craig, Reuben A. (S).....514 W. Superior St.
Craig, Reuben.....514 W. Superior St.
Crawford, Theodore R.....2114 W. Sycamore St.
DeBrota, John, Jr.....3114 Orleans Ct.
Earl, Max M..... 502 S. Berkley Rd.
Elleman, John H.....1838 S. Indiana
Ericson, Homer S.....107 S. Dixon Rd.
Ferry, Paul W. (S).....406 Union Bank Bldg.
Fields, Donald L.....500 Southway Blvd., East
Frazier, John L.....500 Southway Blvd., East
Fretz, Richard C.....215 W. Superior St.
Golper, Marvin N.....1907 W. Sycamore St.
Good, Richard P.....400 S. Berkley Rd.
Grothouse, Carl B.....402 S. Berkley Rd.
Guin, Jere D.....522 Armstrong-Landon Bldg.
Halfast, Richard W..... 402 S. Berkley Rd.
Harshman, James A.....St. Joseph Hospital
Hoyt, John M.....3501 Hawthorne Lane
Hutto, William H.....215 W. Superior St.
Jewell, George M....610 Armstrong-Landon Bldg.
Klingerman, John J.....1507 N. Bell St.
Kremers, George A.....404 S. Berkley Rd.
Lehman, David P.....2804 S. Washington
Longshore, Robert E.....2016 W. Sycamore St.
McClure, Warren N.....319 S. Berkley Rd.
McIndoo, Ralph E. (S).....313 W. Taylor St.
Mendelson, Stanley M.....401 E. Reynolds Dr.
Michael, Robert L.....321 W. Walnut St.
Morrison, William R. (S)..504 Union Bank Bldg.
Murray, Ernest C.....408 W. Mulberry St.
Paris, Durward W...614 Armstrong-Landon Bldg.
Perkins, Powell L.....317 S. Berkley Rd.
Phares, Robert W.....905 W. Mulberry St.
Prather, Philip E.....909 S. Courtland
Radpour, Shokri.....315 S. Berkley Rd.
Ramey, John W. (S).....107½ S. Union St.
Rhorer, Herbert M. (S).....417 W. Sycamore St.
Rinehart, James J.....401 E. Reynolds Dr.
Rudicel, Max.....1907 W. Sycamore St.
Schwartz, Frederick C.....2016 W. Sycamore
Shenk, Earl M. (S).....208½ N. Main St.
Smith, Charles F.....Howard Community Hosp.
Smith, Gloster J.....102½ S. Main St.
Spangler, Jesse S.....215 E. Taylor St.
Trimble, John G.....116 S. Buckeye St.
Wachob, Tom W., Jr.....3520 S. Lafountain
Wible, James H.....317 S. Berkley Rd.

Ware, John R.....Russiaville

HUNTINGTON COUNTY

Huntington

Brubaker, Harold S.....42 W. Park Dr.
Casey, Stanley M.....408 E. Market St.
Clark, Joseph H.....818 W. Park Dr.
Clunie, William A.....323 W. Park Dr.
Cope, Stanton E.....1022 N. Jefferson St.
Doermann, Paul E. 340 E. Market St.
Erehart, Mark G. (S)..Maple Grove Rd., R. R. 8
Eviston, John B. (S).....34 E. Washington St.
Gill, Donald R.....1751 N. Jefferson St.
Grayston, Wallace S. (S).....303 E. Market St.
James, Thomas, Jr.....202 U. B. Publishing Bldg.
Johnston, Robert G. (S).....339 E. Market St.
Marks, Howard H.....248 W. Park Dr.
Meiser, Robert D.....612 N. Jefferson St.
Mitman, Floyd B.....210 W. Park Dr.
Omstead, Trevalyn W.....229 Vine St.
Peare, Reeve B.....1751 N. Jefferson St.
Van Campen, Warren M.....3 Park Moor Dr.
Wagner, Richard.....1355 Guilford

Cooper, B. Trent.....Roanoke
Bennett, J. B.....Warren

Miller, Wayne S.
1926 Park Forest Dr., Flint, Mich.

JACKSON-JENNINGS COUNTIES

Gillespie, Garland R.....Brownstown
Shields, Jack E.....Brownstown
Guthrie, William H.
Muscatatuck State School, Butlerville
Knotts, Slater.....R. R. 3, Columbus

Adair, William K. (S)
115 Armstrong, Crothersville
Bard, Frank B...305 E. Howard St., Crothersville
Butler, Joe B.....508 E. Moore St., Crothersville

Scharbrough, William D.....Ewing

North Vernon

Berkshire, Shaffer B.....Long St.
Calli, Louis J.....408 S. State St.
Ellis, Forrest D.....241 Norris Ave.
Johnson, William A.....245 Norris Ave.
Thayer, Benet W.....20 Jackson St.

Seymour

Baxter, Harry R.....326 N. Walnut St.
Black, Joe M.....502 W. Second St.
Bobb, Kenneth E.....406 S. Chestnut St.
Bosch, Ralph.....635 W. Second St.
Day, William D. C.....410 S. Chestnut St.
Graessle, Harold P. (S).....304 W. Second St.
Martin, Guy.....105 N. Walnut St.
Miller, Harold E.....Vehslage Bldg.
Osterman, Louis H.....315 W. Second St.
Ripley, John W..... 321 Bruce St.
Templeton, Ian S..... 207 N. Pine St.
Wiethoff, Clifford A.....214 N. Walnut St.

JASPER COUNTY

Schantz, Richard.....Remington

Rensselaer

Beaver, Ernest R.....111 Thompson St.
Greene, Robert W.....116 N. Cullen
Jones, Edwin F..... Jasper County Hosp.
O'Brien, Francis E. McKinley and Washington Sts.
Ockerman, Kenneth R.....119 W. Harrison St.
Williams, Paul A.....119 W. Harrison St.

JAY COUNTY

Dunkirk

Entner, Charles L.....125 E. Commerce
Heller, Nelson L. R. (S)...354 E. Washington St.
Shroyer, Herbert L.....244½ S. Main St.
Tate, Elizabeth..... 317 S. Main St.

Andrews, C. Franklin.....R. R. 1, Geneva

Portland

Cripe, William H. 302 N. Meridian St.
Donnally, George A.....Jay County Hospital
Fitzpatrick, James S.....603 W. Arch St.
Gillum, Eugene M.....522 W. Arch St.
Keeling, Forrest E.....504 W. Arch St.
Lyon, Florence M.....127 E. North St.
Morrison, George G.....116 W. Walnut St.
Schneck, Ralph E.....603 W. Arch St.
Spahr, Donald E.....615 W. Race St.
Steffy, Ralph M.....504 W. Arch St.
Vormohr, Joseph F.....604 W. Arch St.

JEFFERSON-SWITZERLAND COUNTIES

Moore, Martha..Hanover Nursing Home, Hanover

Madison

Alcorn, Merritt O.....R. R. 2
Childs, Wallace E.....412 E. Main St.
Davis, Lloyd H. (S).....Madison State Hospital
Fong, Theodore C. C.....Madison State Hospital
Haney, William K.....445 Clifty Dr.
Hare, Francis W., Jr.....722 W. Main St.
Harris, George F.....445 Clifty Dr.
Jolly, Lewis E.....722 W. Main St.
Johnson, Robert D.....722 W. Main St.
Karnafel, Eugene T.....2300 Ross St.
Libbert, Edwin L., Jr.....Madison State Hospital
McAtee, Ott B.....Madison State Hospital
Modisett, Jackson W.....722 W. Main St.
Modisett, Marcella S.....722 W. Main St.
Pratt, Ralph M., Jr.....323 Poplar St.
Riley, Henry S.....722 W. Main St.
Rucker, Warren R.....426 E. Main St.
Shuck, William A.....Odd Fellows Bldg.
Sloan, W. Keith.....426 E. Main St.
Turner, Anna Goss.....602 E. Second St.
Turner, Oscar A. (S).....602 E. Second St.
Zink, Robert O.....722 W. Main St.

Graves, Noel S.....Vevay
Hamilton, Antha A.....Vevay

JOHNSON COUNTY

Lutes, David L. (S)....305 S. Kyle St., Edinburg

Franklin

Andrews, Hugh K.....176 E. Jefferson St.
Bullers, Robert C.....395 S. Home Ave.
Chappel, Alfred T.....100 N. Main St.
Deppe, Charles F.....301 E. Jefferson St.
Ferrara, Joseph F.....1107 N. Main St.
Foster, Robert H. K.....301 E. Jefferson St.
Hibbs, William G.....Masonic Hospital
Jones, Charles A.....251 E. Jefferson St.
Mock, Harry E., Jr.....901 N. Main St.
Province, Oran A.....100 N. Main St.
Province, William D.....100 N. Main St.
Records, Arthur W.....198 E. Jefferson St.
Records, John M.....198½ E. Jefferson St.
Ritteman, George W..Johnson Co. Memorial Hosp.
Stogsdill, Willis W.....176 E. Jefferson St.
Walters, Jack L.....1551 N. Main St.
Waymire, William M.....1551 N. Main St.
Wesemann, Merrill M.....251 East Jefferson St.

Greenwood

Barnes, Helen Beall.....360 S. Madison Ave.
Brown, George E.....374 S. Madison Ave.
Link, Charles W., Jr.....360 S. Madison Ave.
Ogle, Robert W.....365 E. Main St.
Sheek, Kenneth I.....188 S. Madison Ave.
Snodgrass, Robert E.....365 S. Madison Ave.
Tiley, George A.....41 N. Madison Ave.
Young, Joseph W.....360 S. Madison Ave.

Bullington, George E.....Whiteland
Machledt, John H.....Whiteland

KNOX COUNTY

Bicknell

Byrne, Robert J.....207 N. Main St.
Wilson, Guy H.....120 W. Third St.

Springstun, George H.....Oaktown

Vincennes

Anderson, John B.....301 LaPlante Bldg.
Anderson, Richard M.....301 LaPlante Bldg.
Arbogast, Paul B.....915 Main St.
Barrett, Thomas L.....307 S. Fifth St.
Bartlett, Donald T.....307 S. Fifth St.
Beckes, Ellsworth W.....220 N. Fifth St.
Black, Boyd K.....Good Samaritan Hospital
Chattin, Herbert O.....729 Main St.
Coffel, Melvin H.....214 Buntin St.
Corsentino, Bart E.....Good Samaritan Hospital
Curtner, Myron L. (S).....222 N. Sixth St.
Edwards, Edward T.....34 S. Seventh St.
Ewing, Nathaniel D.....719 Nicholas
Hendrix, Charles E.....603 Busseron St.
Hoffman, Doris.....720 Perry St.
Humphreys, Joe E.....1516 N. Second St.
McCormick, Hubert D. (S)....325 LaPlante Bldg.
McDowell, Mordecai M.....611 Dubois St.
McMahan, Virgil C.....609 Dubois St.
Miller, Charles L.....301 American Bank Bldg.
Moore, Robert G.....21 N. Third St.
Nichols, Robert J.....605 Busseron St.
Parmenter, Harry B.....301 American Bank Bldg.
Reilly, James F.....401 Buntin St.
Shaffer, Kenneth L.....404 LaPlante Bldg.
Shanklin, Jack L.....607 Dubois St.
Smith, Ralph O.....603 Busseron St.
Smith, S. Joseph.....301 LaPlante Bldg.
Spencer, Frederic.....429 S. Sixth St.
Stein, Richard H.....301 American Bank Bldg.
Stewart, J. Frank W.....Hillcrest Hospital
Vaughn, Walter R.....615 Dubois St.
von der Lieth, William C.....719 Nicholas
Welch, Norbert M.....615 Dubois St.

Tolbert, Robert D.....4310 Zelar St., Tampa, Fla.

KOSCIUSKO COUNTY

Gill, Dee D.....Leesburg
Urschel, Dan L.....Mentone
Wilson, Wymond B.....Mentone
Pierson, Pearl H.....Silver Lake

Warsaw

Arford, John E.....102 E. Fort Wayne
Baum, John R.....212 S. Indiana
Brooks, Leonard C.....2022 E. Winona Ave.
Cron, William J.....215 S. High St.
Dormire, Robert D.....600 E. Winona Ave.
DuBois, Charles C. (S).....800 E. Center St.
Hashemi, Hossein.....215 S. High St.
Haymond, George.....Ted Williams Dr., R. R. 2
Hillery, John L..... 208 E. Center St.
Hogle, Frank D.....R. F. D. 2
Keough, Thomas F.....600 E. Winona Ave.
Reed, Edgar A.....422 S. Buffalo St.
Schlemmer, George H.....Murphy Medical Center
Shrader, Carl E.....600 E. Winona Ave.
Thomas, Everett W.....212 S. Indiana

LAGRANGE COUNTY

Taylor, M. Reed, Jr.....Howe
Yunker, Philip E.....Howe

LaGrange

Benedict, Charles D.....203 W. Wayne St.
Flannigan, Harley F.....213 W. Lafayette
Studebaker, Lloyd R.....Medical Bldg.

Williams, John H.....Shipshewana
Lehman, Kenneth M.....Topeka

LAKE COUNTY

Cedar Lake

Babcoke, Gary A.....R. R. 2, Box 337
King, Robert W.....R. R. 1, Box 4
Miller, Donald C.....R. R. 2, Box 337
Misch, William.....R. R. 2, Box 337

Crown Point

Becker, Philip H...Lake County Tuberculosis San.
Birdzell, John P.....124 N. Main St.
Carroll, Mary E.....124 N. Main St.
Doherty, Raymond J.....47 W. 68th Place
DuSold, Donald D.....R. R. 1, Box 122
Fadul, Armand.....47 W. 68th Pl.
Gray, Daniel E.....182 W. North St.
Gutierrez, Peter E.....123 N. Court St.
Horst, William N.....123 N. Court St.
Monroe, F. Bruce.....40 West 73rd St.
Russo, Andrew E.....224 S. Court St.
Steele, Everett B.....109 E. North St.
Troutwine, William R.....224 S. Court

Theobald, Sterling.....212 Joliet St., Dyer

East Chicago

Barron, Elmer A.....3406 Guthrie St.
Benchik, Frank A.....4712 Magoun Ave.
Boyd, Charles S.....4739 Melville Ave.
Boys, Fay F.....4712 Magoun Ave.
Braun, Benjamin D.....St. Catherine's Hospital
Broomes, Edward L. C.....2402 Broadway
Bryant, Edward G.....2220 Broadway
Campagna, Ettor A.....3406 Guthrie St.
Dainko, Alfred J. 823 W. Chicago Ave.
Fedor, Thomas A.....3406 Guthrie St.
Fleischer, Jacob C.....4035 Elm St.
Frahm, Charles.....4321 Fir St.
Gardiner, H. Glenn.....3210 Watling
Geronimo, Rita R. V.....3528 Main St.
Govorchin, Alexander.....4614 Baring
Grosso, William G.....1919 E. Columbus Dr.
Harper, James W.....3847 Euclid
Hayes, Jesse D.....4804 Alexander
Hernandez, I. C.....1802 Columbus Dr.
Irish, Wilbur J.....806 W. Chicago Ave.
Joffe, Herman.....4035 Elm St.
Johns, David R. (S).....1211 Beacon St.
Jones, Harold N.....1820 Columbus Dr.
Komoroske, John E.....4710 Indianapolis Blvd.
Kopanko, Bernard F.....823 W. Chicago Ave.
Levin, Eli L. (S).....4105 Grand Blvd.
McGuire, Desmond F. (S)....3429 Michigan Ave.
Marks, Ora L.....815 W. Chicago Ave.
Marquinez, Adoracion A.....4124 Elm St.
Milan, Shijachki D. 622 W. Chicago Ave.
Nicosia, John B.....1802 E. Columbus Dr.
Payne, Arthur C.....2020 Broadway
Perdomo, Octavio J..... 3406 Guthrie St.
Ramos, John.....3807 Main St.
Reitman, Paul H.....4321 Fir St.
Romero, Plinio.....3526 Main St.
Serna, Carlos A.....4035 Elm St.
Serna, Jesus A.....3619 Main St.
Shulruff, Harry I.....3701 Main St.
Teegarden, Joseph A., Jr...1919 E. Columbus Dr.
Teplinsky, Louis L.....1802 E. Columbus Dr.
Trepagnier, Francis B.....3628 Main St.
Vergara, Abelardo.....4124 Elm St.
Walker, Adolph P.....1820 E. Columbus Dr.
Wang, Tieh C.....4321 Fir St.
Zallen, Stanley G.....720 W. Chicago Ave.

Gary

Abramson, Allan L.....3290 Grant St.
Agana, Adriano A.....6121 Birch
Alfano, Paul A.....2717 Wabash
Almquist, Carl O.....504 Broadway
Alvarez, Paul.....4655 Broadway
Ambrozaitis, Kazys.....1600 W. Sixth Ave.
Amico, Pasquale J.....3807 Washington
Angeles, Uldarico A.....1600 W. Sixth Ave.
Armalavage, Leon J.....2620 W. Fifth Ave.
Barton, Reginald R.....427 S. Lake
Behn, Walter M.....1514 W. Fifth Ave.
Bendler, Carl H.....3290 Grant St.
Bergal, Milton B.....504 Broadway
Bernard, Marvin R.....4431 Broadway
Bernoske, Daniel G.....2306 W. 65th St.
Bills, R. James.....504 Broadway
Bills, Robert N.....504 Broadway
Borak, Walter J.....5000 Ridge Road
Bornstein, Herschel.....3290 Grant
Brady, Samuel G.....757 Broadway
Brand, Anna.....4801 W. Fifth Ave.
Brandman, Harry.....504 Broadway
Brincko, John.....504 Broadway
Brink, Calvin C. (S).....504 Broadway
Brown, David B.....504 Broadway
Brown, Leo R.....4645 Broadway
Burcham, James B.....738 Broadway
Cahue, Antonio R.....6111 Harrison St.
Carberry, George A.....3656 Grant St.
Carbone, Joseph A.....6111 Harrison St.
Carey, J. Albert.....2964 W. 11th Ave.
Carmody, Raymond F.....6111 Harrison Street
Choslovsky, Sydney.....1600 W. Sixth Ave.
Chube, David D.....1606 Broadway
Cohen, Hyman.....1600 W. Sixth Ave.
Cooper, Leo K.....504 Broadway
Corrao, Gaetano.....2471 Colfax
Daniel, Robert A.....738 Broadway
Darling, Dorothy R.....807 Fayette
Dasaro, George E.....504 Broadway
Davis, Neal.....1600 W. Sixth Ave.
De Bois, Elon.....1080 Roosevelt
Dian, August J.....504 Broadway
Dierolf, Edward J.....504 Broadway
Disney, Charles T.....504 Broadway
Donchess, Joseph C.....215 Broadway
Duncan, John S.....2165 W. 11th Ave.
English, Hubert M.....673 Broadway
Espy, Theodore R.....1901 Broadway
Fadell, Matthew J.....6111 Harrison St.
Galante, Vincent J.....St. Mary Mercy Hospital
Gallinatti, John J.....554 S. Lake
Gilles, Pierre.....1649 Broadway
Glover, William J.....6111 Harrison St.
Goldberg, Harold B.....3656 Grant
Golding, Robert F.....P. O. Box 727
Goldstone, Adolph.....3229 Broadway
Goldstone, Arthur.....3578 Buchanan
Goldstone, Joseph.....3229 Broadway
Goldstone, Robert J.....717 Newton St.
Goldstone, Sidney R.....3233 Broadway
Goodwin, Thomas.....3820 Central, East Gary
Grant, Benjamin F.....1706 Broadway
Gregoline, Amadeo F.....729 Broadway
Gregoline, Eugene.....330 Taney
Hadey, James H.....2620 W. Fifth Ave.
Halikiopoulos, Harry J.....504 Broadway
Han, Daniel.....1600 W. Sixth Ave.
Hedrick, James T.....1649 Washington St.
Hodurski, Zigfield.....4319 Broadway
Hoit, Leonard.....504 Broadway
Holliday, Alfonso.....1649 Broadway
Jahns, Albin A.....2318 W. Fifth St.
Johnson, Arnold L.....1903 Broadway
Johnson, Lonnie B.....123 W. 21st St.
Johnson, William H.....3656 Grant
Kaltenthaler, Albert.....1600 W. Sixth Ave.
Kamen. Jack M.....1600 W. Sixth Ave.
Kendrick, Frank J.....504 Broadway
Khaton, Odessa M.....1649 Broadway
Kobrin, Meyer W.....3229 Broadway
Kolettis, John G.....504 Broadway
Kopcha, Joseph E.....504 Broadway
Korn, Jerome M.....3290 Grant St.

Lazo, Vicente R.....765 Broadway
Lebioda, Henry S.....6111 Harrison St.
Lewis, George N.....504 Broadway
Lewis, Lucien A.....1649 Broadway
Lipschutz, Harold.....504 Broadway
Lipsey, Alfred J.....504 Broadway
Loh, Hwei Ya (Chang).....212 Cleveland St.
Loh, Wei-Ping.....212 Cleveland St.
Lorenty, Thaddeus B.....504 Broadway
Lovell, Martin H.....124 W. 25th Ave.
Lutz, Georgianna.....504 Broadway
Lytwakiwsky, Anatol.....552 S. Lake
McDonald, Walter E.....1721 Broadway
Majsterek, Stanley L.....1034 Aetna St.
Manalo, Francisco S.....538 Lincoln
Marcus, Morris C. (S).....3229 Broadway
Marshall, Millard R.....1215 Vermillion St.
Mather, J. Winford....2250 Ripley St., East Gary
May, Richard M.....583 Broadway
Mayorga, Alfredo.....558 Mathews
Milos, Robert J.....504 Broadway
Minczewski, Richard C.....5490 Broadway Plaza
Mitchell, Georgia B.....1706 Broadway
Molengraft, Cornelius J.....504 Broadway
Moore, Edwin G.....26 E. 15th Ave.
Morris, Hyman R.....3229 S. Broadway
Moswin, Jack A.....504 Broadway
Mott, William H.....2009 Broadway
Nelson, Walfred A.....559 S. Lake St.
Oberlander, Seymour.....3290 Grant St.
Olivo, Marciano T.....1600 W. Sixth Ave.
Olson, Leslie D.....2318 W. Fifth Ave.
Ornelas, Joseph P.....3656 Grant St.
Pappas, Eddie T.....2717 Wabash Ave.
Parratt, Louis W.....708 Broadway
Penn, Robert A.....3792 Central Ave., East Gary
Pettis, Arthur G.....1600 W. Sixth Ave.
Pierson, Howard.....620 E. 10th Pl.
Platis, James M.....504 Broadway
Poracky, Bernard F.....504 Broadway
Pruitt, J. Edward.....4655 Broadway
Radigan, Leo R.....2318 W. Fifth Ave.
Reynolds, James S.....504 Broadway
Richter, Samuel.....504 Broadway
Riordan, John F.....1600 W. Sixth Ave.
Robinson, Walter K.....500 N. Montgomery St.
Rosenbloom, Philip J.....571 Lincoln St.
Ross, David E., Jr.....633 E. 21st St.
Roth, Leo.....3229 Broadway
Roth, Melvin I.....3229 Broadway
Rubin, Simon S.....504 Broadway
Ryan, Hubert J.....5490 Broadway Plaza
Sala, Joseph J.....2705 Wabash
Sala, Walter R.....2705 Wabash
Schulz, Kurt J.....4655 Broadway
Schwartz, Mandel.....540 Tyler
Scully, John T.....2318 W. Fifth Ave.
Senese, Thomas J.....504 Broadway
Shellhouse, Michael.....3811 Washington St.
Shevick, Alexander.....2620 W. Fifth Ave.
Slama, George F.....4431 Broadway
Slama, John T.....4481 Broadway
Speer, Thomas A.....Gary Sheet & Tin Mills
Spellman, Frank W.....401 S. Lake
Spivack, Mary.....504 Broadway
Stern, Mona K.....3830 Central, East Gary
Stoycoff, Christ M. (S).....860 Broadway
Thomas, Daniel D.....3290 Grant St.
Thomas, Gerald J.....3920 Grant St.
Turgi, Robert W.....6111 Harrison St.
Valencia, Monico....2606 Central Ave., East Gary
Verplank, Grover L. (S).....2701 W. 57th Ave.
Voorhies, McKinley.....1606 Broadway
Walters, Eleanor.....602 Broadway
Washington, G. Kenneth.....1645 Broadway
Weiskopf, Henry S.....504 Broadway
Wharton, Russell O. (S).....6559 Ash Place
Whitaker, Jack.....540 Tyler
Williams, Alexander S.....436 W. 25th St.
Williams, Edwin D.....436 W. 25th St.
Williams, Fred R.....2501 Polk St.
Wimmer, Robert N. (S).....9 W. Sixth Ave.
Yast, Charles J.....6111 Harrison St.
Yocum, Paul S., Jr.....504 Broadway
Yocum, Paul S., Sr.....757 Broadway
Yocum, William S.....790 Broadway
Young, George M.....3656 Grant St.
Young, Robert L.....504 Broadway
Zucker, Edward.....504 Broadway

Griffith

Carpenter, Bennie F.....1212 N. Broad
Lundeberg, Ralph A.....1212 N. Broad St.
Moleski, Walter L.....401 N. Broad St.
Purcell, Richard J.....433 N. Glenwood
Siekierski, Joseph M.....145 N. Griffith

Hammond

Alfano, Joseph E.....5252 Hohman Ave.
Allegretti, Michael L.....6850 Hohman Ave.
Bacevich, Andrew J.....2450 169th St.
Balaguer, Carmen V.....St. Margaret Hospital
Beconovich, Robert.....6850 Hohman Ave.
Bethea, Dennis A. (S).....1021 Field St.
Church, Robert A.....837 169th St.
Costello, Albert J.....30 Douglas St.
Cotter, Edward R.....2415 169th St.
Davis, Thomas N. III.....5246 Hohman Ave.
Eggers, Ernest L. (S).....635 165th St.
Eggers, Henry W.....30 Douglas St.
Egnatz, Nicholas.....820 Highland
Elledge, Ray (S).....6415 Forest Ave.
Fischer, Burnell.....St. Margaret Hosp.
Fitzpatrick, William J.....30 Douglas St.
Friedman, Isadore E.....7217 Indianapolis Blvd.
Gevirtz, Milton B.....6850 Hohman Ave.
Griffith, Thomas E.....5231 Hohman Ave.
Hopkins, Joseph R.....430 Conkey
Howard, William Harry.....5231 Hohman Ave.
Husted, Robert G.....6850 Hohman Ave.
Jones, Eli S.....30 Douglas St.
Kenney, Francis D.....30 Douglas St.
Kmak, Chester J.....6737 Magoun Ave.
Kolanko, Leon A.....30 Douglas St.
Koransky, David S.....6860 Hohman Ave.
Kuhn, Arthur J.....112 Rimbach St.
Kuhn, Hedwig S.....112 Rimbach St.
LaFollette, Forrest R.....2450 169th St.
Lautz, Herbert A.....112 Rimbach St.
Long, Keith J.....30 Douglas St.
McVey, Clarence A. (S).....5231 Hohman Ave.
Mansueto, Mario D.....5231 Hohman Ave.
Marcus, Emanuel.....7127 Indianapolis Blvd.
Marks, Salvo P.....6860 Hohman Ave.
Maroc, James A.....837 169th St.
Marshall, Wilbur J., Jr.....30 Douglas St.
Mason, Richard L.....132 Rimbach St.
Modjeski, Joseph R.....5451½Hohman Ave.
Montes, Herminio Y.....5217 Hohman Ave.
Neal, Leonard W.....6850 Hohman Ave.
Nodinger, Louis.....540 165th St.
Palmer, Barron M. F.....6134 Columbia
Panares, Solomon V.....5434 Hohman Ave.
Peck, Edward A.....430 Conkey St.
Peiffer, Geraldine M.....St. Margaret Hospital
Pilot, Jean.....5231 Hohman Ave.
Premuda, Franklin F.....6625 Kennedy Ave.
Ramker, Daniel T.....7040 Kennedy Ave.
Rawlins, Carolyn M.....6223 Hohman Ave.
Remich, Antone C.....30 Douglas St.
Rendel, Donald T.....5231 Hohman Ave.
Repay, Walter A.....429 Conkey St.
Rhind, Alexander W.....422 Conkey St.
Rosenthal, Carl.....St. Margaret Hospital
Rosevear, Henry J.....30 Douglas St.
Row, Perrie Q.....6712 Hohman Ave.

Rubright, Robert L.....7258 Forest Ave.
Sargent, Wallace B.....112 Rimbach
Schlesinger, Daniel J.....6850 Hohman Ave.
Schulfer, Richard J.....7134 Calumet Ave.
Schwartz, Mary M.....St. Margaret Hospital
Shapiro, Joseph.....2450 169th St.
Shapiro, Seymour W.....2450 169th St.
Smith, Jerald E.....6850 Hohman Ave.
Smitley, Roger P.....30 Douglas St.
Solis, Roger V.....422 Conkey St.
Stasick, Murray.....7330 Indianapolis Blvd.
Stern, Samuel L.....5231 Hohman Ave.
Tilka, Edward C.....7134 Calumet Ave.
Weissman, Charles G.....5246 Hohman Ave.
White, Gilbert H., Jr.....2450 169th St.
Wong, Samuel N.....7127 Indianapolis Blvd.

Highland

Angel, Virgil E.....2933 Jewett
Bonaventura, Angelo P.....2914 Highway St.
Eugenides, Tatiana.....8136 Kennedy
Santiago, Iluminada.....8127 Kennedy
Sroka, Stanley J.....2942 Highway Ave.
Vore, Hugh A.....8680 Prairie Ave.

Hobart

Carter, John O.....295 S. Wisconsin St.
Doneff, Ronald H.....R. 1, U. S. 6
Faulkner, Donald J.....295 S. Wisconsin St.
Kellar, Philip E.....701 N. Ridge
Krsek, Archie J.....10 N. Michigan Ave.
Markle, Joseph G.....201 Main St.
Parker, Harry C. (S).....831 Garfield St.
Pike, Warren H.....108 E. Third St.
Reed, John.....10 N. Michigan Ave.
Thomas, Andrew C.....124 Main St.
Weiss, John T.....295 S. Wisconsin St.

Lowell

Mirro, John A.....317 W. Commercial Ave.
Smith, Robert D.....308 E. Commercial
Templin, David B.....308 E. Commercial

Munster

Alt, Edward M., Jr.....7550 Hohman Ave.
Arbeiter, Herbert I.....7550 Hohman Ave.
Arrowsmith, James L.....7550 Hohman Ave.
Bombar, Leslie E.....8318 Oakwood
Branco, Arthur M.....7905 Calumet
Brenner, Howard B.....7905 Calumet Ave.
Chael, Thomas C.....7905 Calumet Ave.
Ciatteo, Carmen T.....7905 Calumet Ave.
Espino, Jose C.....8144 Calumet Ave.
Fetrow, Kenneth O.....7905 Calumet Ave.
Fox, Jack M.....7550 Hohman Ave.
Hammond, Stanley.....7905 Calumet Ave.
Hehemann, William V.....7905 Calumet Ave.
Keplinger, James E.....7550 Hohman Ave.
Kott, Alexander.....7550 Hohman Ave.
Lanman, John U.....8146 Calumet Ave.
Larrabee, James F.....130 Ridge Road
McLean, James S.....1836 Ridge Road
Madlang, Rodolfo M.....7550 Hohman Ave.
Mason, John C.....7905 Calumet Ave.
Mintz, Alfred M.....7550 Hohman Ave.
Navarre, Vincent J.....7628 Manor Ave.
Paul, Eudell G.....7550 Hohman Ave.
Portney, Fred R.....7905 Calumet Ave.
Rasch, George C., Jr.....509 Ridge Road
Rudolph, Franklin G.....7550 Hohman Ave.
Santare, Vincent J.....7550 Hohman Ave.
Schmitt, Robert J.....7905 Calumet Ave.
Schwartz, Jack.....7550 Hohman Ave.
Snyder, Jerome A.....7905 Calumet Ave.
Stevens, Edwin W.....7905 Calumet Ave.
Sweany, Stanford K.....7550 Hohman Ave.
Trachtenberg, Lee.....8231 Calumet Ave.
Westhaysen, Peter V.....7550 Hohman Ave.
Wooden, Thomas F.....8351 Crestwood Ave.

Portage

Hoham, Frederick D.....14000 Central

Martirez, N. A.....Rts. 41 and 30, Schererville
Skeen, Earl D. (S)..419 N. Sunnyside, South Bend
Brauer, Abraham A.
Beatty Memorial Hosp., Westville

Whiting

Becker, Samuel W.....2075 Indianapolis Blvd.
Best, Robert C.....2075 Indianapolis Blvd.
Brennan, William C.....2075 Indianapolis Blvd.
Feinberg, Irwin I.....2075 Indianapoils Blvd.
Ferry, John L.....2075 Indianapolis Blvd.
Frankowski, Clementine E...1907 New York Ave.
Greisen, Jack G.....2075 Indianapolis Blvd.
Gustaitis, John W.....2075 Indianapolis Blvd.
Kudele, Louis T.....1321 119th St.
Polite, Nicholas L.....2075 Indianapolis Blvd.
Reed, Ronald R.....2075 Indianapolis Blvd.
Rudser, Donald H.....2075 Indianapolis Blvd.
Silvian, Harry A.....1010 119th St.
Smith, Theodore J.....1542 Roberts
Sokol, Allen B.....2075 Indianapolis Blvd.
Stecy, Peter.....1902 Indianapolis Blvd.
Steen, Lowell H.....2075 Indianapolis Blvd.
Troy, Jack M.....2075 Indianapolis Blvd.
Weinberg, Benjamin A. 1346 119th St.

Bakos, Edward R.....7203 Sarah, Apt. 4, Maplewood 17, Mo.
Dimitroff, Lambro.....211 Gold Coast Line Calumet City, Ill.
Dumanian, Ara V.....18668 Dixie Highway, Homewood, Ill.
Egnatz, Charles D.....302 Aachen Rd., Fort Ord, Calif.
Feldner, Ronald P...704 Wentworth, Calumet City, Ill.
Foster, Douglas L.
1316 Indiana Ave., Topeka, Kansas
Hayes, Frank W.....Letterman Gen. Hosp., Presidio of San Francisco, Calif.
McMichael, Frank J. (S)..Box 277, Hernando, Fla.
Murphy, Joseph F.....3508 Ridge Rd., Lansing, Ill.
Seyler, Anna G.....2780 Hillcrest Dr., LaVerne, Calif.
Tsatsos, George C.....20 S. Hudson St., Hartford, Conn.
Tyrrell, Joseph J.....800 State Line, Calumet City, Ill.
Tyrrell, Thomas C.
800 State Line, Calumet City, Ill.
Yanson, Mannfredo R. S...P.O. Box 2024, Oxnard, Calif.

LA PORTE COUNTY

Oak, David D., Jr.....Hanna
Oak, David D., Sr. (S).....LaCrosse

La Porte

Backer, George P.....806 Maple Ave.
Backer, Mary B.....903 Indiana Ave.
Carpentier, James R.....1200 Michigan Ave.
Carter, Fred S.....1200 Michigan Ave.
Cartwright, Jack D.....1003 Indiana Ave.
Datzman, Basil J.....216 E Street
Deren, Matthew J.....1012 Michigan Ave.
Durham, Lowell J.....316 Pine Lake Ave.
Erwin, W. Robert.....216 E St.
Farnsworth, Samuel A.....1012 Michigan Ave.
Feinn, Harry S.....1013 Indiana Ave.
Fischer, Carlton N.....1001 Maple Ave.
Kelsey, Robert M., Jr.....1200 Michigan Ave.

Kelsey, Robert M., Sr.....702 Maple Ave.
Kepler, Robert W.....708 Harrison St.
Kistler, James J.....911 Maple Ave.
Lansford, Kenneth G.....1200 Michigan Ave.
Larson, Goyt O.....1110 Indiana Ave.
Mead, Frank E.....901 Indiana Ave.
Moore, William G.....1200 Michigan Ave.
Mueller, Edwin C.....1200 Michigan Ave.
Muhleman, Charles E.....1200 Michigan Ave.
Philbrook, Seth S.....705 Harrison St.
Predd, Adolph C.....909 Madison St.
Richter, John C.....1200 Michigan Ave.
Sanchez, Jose D.....1003 Indiana Ave.
Scott, John S.....806 Maple Ave.
Sirugo, Aldo C.....1200 Michigan Ave.
Sprecher, James J. J.....102 Lincolnway
Tabaka, Francis B.....1201 Michigan Ave.
von Asch, George.....912 Monroe St.
Wolf, William E.....Lakewood Lair, The Island

Michigan City

Armstrong, Thomas D.....120 W. Ninth St.
Arney, Amos.....125 E. Fifth St.
Baker, Warren.....427 Warren Bldg.
Balingit, Benjamin L.....214 E. 10th St.
Bankoff, Milton L.....125 E. Fifth St.
Bergan, Joseph A.....217 W. Homer St.
Berkson, Myron E.....801 Washington St.
Carlson, Norman R.....913 Wabash St.
Cleveland, John B.....2222 E. Michigan St.
Fargher, Francis M.....907 Washington St.
Frost, Robert J.....817 Pine St.
Gardner, Melvin D.....801 Washington St.
Gardner, Russell A.....801 Washington St.
Gilmore, Robert W.....304 Warren Bldg.
Gilmore, Russell A. (S).....304 Warren Bldg.
Given, Everett H.....907 Washington St.
Hay, Gene R.....515 Pine St.
Henderson, Norman C.....131 E. Eighth St.
Hillenbrand, Charles.....128 W. 10th St.
Jones, King S.....328½ Franklin St.
Kemp, John T.....122 E. Seventh St.
Kerr, Charlotte H.....723 Franklin St.
Kerr, John E.....723 Franklin St.
Kerrigan, John F.....916 Washington St.
Kerrigan, Robert L. (S).....916 Washington St.
Kubik, Francis J.....902 Pine St.
Liddell, Charles K.....508 Pine St.
Mannion, Rodney A.....723 Franklin St.
Marske, Robert L.....311-13 Warren Bldg.
McGue, Frank J.....801 Washington St.
Miller, Maurice.....125 E. Fifth St.
Milne, Walter S.....916 Washington St.
Mladick, Edward A.....1412 Franklin St.
O'Brien, Raymond J.....1412 Franklin St.
Olson, William H.....509 Willard Ave.
Paul, Leonard G.....515 Pine St.
Phillips, John H.....801 E. 11th St.
Pilecki, Peter J.....125 E. Fifth St.
Plank, C. Robert.....732 E. Pine St.
Quitasol, Zoilo A., Jr.....125 E. Fifth St.
Reed, Nelle C. (S).....3210 Tilden Ave.
Stark, William A.....1412 Franklin St.
Taub, Robert G.....125 E. Fifth St.
Tunnell, Harry D.....219 E. Sixth St.
Walters, William H.....Warren Bldg.
Warren, Lewis T.....2936 Belle Plaine
Weeks, Patrick H. (S).....305 N. Carroll Ave.
Weiss, Albert E.....125 E. Fifth St.
Zalac, Donald A.....732 Pine St.

Weinstock, Adolph.....Rolling Prairie
Moosey, Louis.....Union Mills
Carter, William D...506 Roosevelt Rd., Walkerton
Rohrer, Bryce B...506 Roosevelt Rd., Walkerton
Benz, Owen F.....Wanatah

Westville

Bone, James A.....Beatty Memorial Hospital
Constan, Evan.....Beatty Memorial Hospital
Dieter, William J.....Box 667
Hetman, Mitchell J.....Westville
Johnston, Donald D.
Beatty Memorial Hospital
Matthew, John R.....Beatty Memorial Hospital
Meyer, Hans.....Beatty Memorial Hospital
Morton, David P.....Beatty Memorial Hospital
Oster, Jack H.....Beatty Memorial Hospital
Salzburg, Herbert E....Beatty Memorial Hospital
Sennett, Cecil M. (S)..Beatty Memorial Hospital
Smith, William M.....Beatty Memorial Hospital

Elshout, Clem H.....2001 Washtenaw Ave.,
Ann Arbor, Mich.

LAWRENCE COUNTY

Bedford

Allen, L. Howard.....1622 24th St.
Austin, Richard P...209 Citizens Nat'l Bank Bldg.
Benham, Lawrence E...310 Stone City Bank Bldg.
Bridwell, Edgar.....1626 24th St.
Duncan, Raymond.....2900 W. 16th St.
Dusard, Joseph C...304 Citizens Nat'l Bank Bldg.
Edmonds, Kendrick.....1303 15th St.
Emery, Charles B.....1027 15th St.
Fountaine, Thomas J.....1618 24th St.
Hammel, Howard T.....1501 J St.
Hawkins, Richard D.....2900 W. 16th St.
Kasting, Gerald....206 Citizens Nat'l Bank Bldg.
Kerr, Donald M.....2900 W. 16th St.
Morrow, Robert J.....1317 L St.
Noe, William R.....2900 W. 16th St.
Reuter, John W.....1310 16th St.
Scherschel, John P.....1711 H St.
Waldo, Guy H.....2900 W. 16th St.
Wohlfeld, Julius B.....1222 15th St.
Woolery, Richard H.....1310 W. 16th St.

Hamilton, James R...111 S. Seventh St., Mitchell
Oswalt, James T.....Mitchell
Robinson, William H.....124 N. Sixth St., Mitchell

MADISON COUNTY

Alexandria

Gaunt, Everett W.....214 E. John
Leroy, Alvin G.....1309 N. Harrison St.
Overpeck, George H.....313 N. Harrison St.
Owen, Thomas F.....313 N. Harrison St.
Shafer, Richard H.....111 S. Harrison St.

Anderson

Aagesen, Walter J.....702 Citizens Bank Bldg.
Armington, Charles L...655 Anderson Bank Bldg.
Austin, Charles E.....1612 Westwood Ave.
Baughn, William L.....Guide Lamp
Beeler, Franklin K.....1931 Brown St.
Bixler, Donald P.....1931 Brown St.
Blassaras, Crist A.....2005 Broadway
Bowers, Charles R.....207 Anderson Loan Bldg.
Brauchla, Carl H. (S).....117 W. 17th St.
Bridges, Alvin L.....1302 Madison Ave.
Brock, Earl E. (S)....412 Anderson Bank Bldg.
Brown, James M.....12 W. 29th St.
Buckles, David L.....St. John's Hospital
Bush, Edward R.....704 E. Eighth St.
Castetter, Gregory K.....126 W. 12th St.
Dixon, Rex W.....934 W. Eighth St.
Doenges, James L.....1931 Brown St.
Donaldson, Frank C.....1931 Brown St.
Drake, James R.....229 Citizens Bank Bldg.
Drake, John C.....604 Anderson Bank Bldg.
Drennen, Robert V.....1424 E. Eighth St.

Dulin, Basil B.....St. John's Hospital
Ellis, Seth W.....717 Anderson Bank Bldg.
Elsten, Aubrey W.....512 Anderson Bank Bldg.
Faust, Howard M., Jr.....1508 N. Madison Ave.
Ferguson, Donald H....402 Anderson Bank Bldg.
Fischer, Warren E.....St. John's Hospital
Gahimer, Joe E.....521 Citizens Bank Bldg.
Gante, Henry W. (S).....2005 Nichol Ave.
Jarrett, Paul E.....315 Citizens Bank Bldg.
Johnson, David G.....1504 N. Madison Ave.
Jones, Albert T.....3316 Cherry Rd.
Jones, Horace E.....1110 Meridian St.
Kelly, Wendell C.....704 E. Eighth St.
Kiely, John T.....1931 Brown St.
King, Joseph W.....1110 N. Meridian St.
Kopp, William R.....333 Jackson St.
Lamey, James L.....447 Citizens Bank Bldg.
Lamey, Paul T.....423 Citizens Bank Bldg.
Land, Richard N.....523 Citizens Bank Bldg.
Larmore, Joseph L.....612 Anderson Bank Bldg.
Litzenberger, Sam W...610 Citizens Bank Bldg.
Long, Paul L.....710 Anderson Bank Bldg.
McDonald, Virgil G. (S)....1110 N. Meridian St.
Meister, Doris (S).....315 W. Ninth St.
Moneyhun, James E.....621 Citizens Bank Bldg.
Morris, Robert A.....1309 Park Road
Neale, Alfred E.....1931 Brown St.
Nesbit, Leonard L.....415 Citizens Bank Bldg.
Patterson, William K...713 Anderson Bank Bldg.
Polhemus, Warren C.....1803 Pearl St.
Quickel, Daniel S. (S).....608 Central Way
Reed, Roger R.....412 Anderson Bank Bldg.
Rosenbaum, Lloyd E.....647 Citizens Bank Bldg.
Ross, Guy E.....1931 Brown St.
Sharp, William L.....449 Citizens Bank Bldg.
Sheldon, Suel A.....508 Anderson Bank Bldg.
Stamper, Joseph H.....412 Anderson Bank Bldg.
Stamper, Robert J.....412 Anderson Bank Bldg.
Starks, William O.....1307 Park Rd.
Stinson, William M.....333 Jackson St.
Taylor, James A.....Delco Remy Div.
Wagoner, John R.....708 Anderson Bank Bldg.
Webb, Harry D.....515 Citizens Bank Bldg.
Weiss, Louis L.....1225 N. Madison
Wilder, Gordon B.....338 W. Eighth St.
Williams, Francis M.....1132 Central Ave.
Williams, Robert H.....1132 Central Ave.
Woodbury, Clarence R.....1307 Park Rd.
Wright, Cecil S.....207 Beverly Terrace

Elwood

Buechler, William F.....1817 S. A St.
Drake, Marion C.....1201 Main St.
Fitzpatrick, Harry W. (S)..1309 S. Anderson St.
Hanson, Martin F.....1102 S. Anderson St.
Hoppenrath, William H. (S).....1300 Main St.
Laudeman, Walter A.....1515 N. A St.
Oldag, George E.....1301 Main St.
Ploughe, Ralph R.....517 S. Anderson St.
Scea, Wallace A.....1601 S. Anderson St.
Ulrey, Robert P.....1201 Main St.

Kepner, Robert S.....Chesterfield
Austin, Maynard A.
3900 Washington Ave., Evansville
Ferrell, Mars B.....Fortville
Bishop, Harry A.....Frankton
Hammer, Jay W.
3340 N. Rex Dr., Indianapolis (2)
Ridgway, Alton H.....Lapel
Rinne, John I. (S).....Lapel
Williams, Robert D.....Markleville
Reynolds, Ralph E.....Middletown
Leahy, Howard J.....103 E. State St., Pendleton
Van Ness, William C.....Summitville

Pierce, Fredrick H. Central Foundry Div.
General Motor's Corp., Danville, Ill.

MARION COUNTY

(Zip Code 462 plus zone number.)

Beech Grove

Berger, Morley.....902 Main St.
Christie, Marvin C.....3655 S. Sherman Dr.
Dill, Charles W.....3655 S. Sherman Dr.
Kim, Young D.....136 N. 17th St.
Ramage, Walter F.....244 S. First St.
Reilly, Eva F.....St. Francis Hospital
Zerfas, Charles P. A.....926 Main St.

Kime, Edwin N. (S)
1007 Greenwood Ave., Bloomington
Hasewinkel, Carroll W...R. R. 2, Box 354, Carmel
Harris, Paul N.
Eli Lilly & Co., Toxicology Bldg. Greenfield
Pierce, Emmett C., Jr.
Eli Lilly & Co., Box 708, Greenfield
DeMotte, C. Bowen...540 N. Madison, Greenwood
Onyett, Harold R.....R. R. 3, Box 32, Greenwood

Indianapolis

A

Addleman, Robert H.....5540 Woodside Dr. (8)
Adkins, Harold C.....409 E. 30th St. (5)
Albertson, Frank P.....3544 W. 16th St. (22)
Albrecht, Willard H..7400 Hollingsworth Dr. (68)
Aldred, Allen W.....2221 W. 79th St. (60)
Aldrich, Harry D.....201 Hume Mansur Bldg. (4)
Aldrich, Howard....4316 E. Washington St. (1)
Alexander, Ezra D.....906 W. 27th St. (23)
Alig, Vincent B.....1815 N. Capitol Ave. (2)
All, Barbara B.....I. U. Medical Center (7)
Allen, Robert K.....3202 N. Meridian St. (8)
Alvis, Edmond O.....320 Hume Mansur Bldg. (4)
Anderson, James W.....623 N. West St. (2)
Anderson, Wendell C.
Indiana State Board of Heatlh,
1330 W. Michigan St. (7)
Anshutz, William M.....Methodist Hospital (7)
Antreasian, Berj.....4829 E. 38th St. (18)
Appel, Richard H....320 Hume Mansur Bldg. (4)
Arbogast, John L.....I. U. Medical Center (7)
Arbuckle, William E. (S)..1150 S. Sheffield (22)
Armer, Robert M.....4701 W. 30th St. (24)
Armstead, John W.....2140 N. Capitol Ave. (2)
Arnold, Aaron L.....607 E. 38th St. (5)
Arnold, Robert D.....5470 E. 16th St. (18)
Aronson, Sidney S...618 Hume Mansur Bldg. (4)
Assue, Clare M.....LaRue D. Carter Hospital (7)
Avery, George O.....17 S. Traub (22)

B

Bachmann, Arnold J.....3440 N. Meridian St. (8)
Badenhauser, Walter E., Jr.
I. U. Medical Center (7)
Baird, Melvin S.....17½ W. 22nd St. (2)
Bakemeier, Otto H...5503 E. Washington St. (19)
Bakemeier, Robert E. 5503 E. Washington St. (19)
Balch, James F. Jr.....I. U. Medical Center (7)
Ball, Joseph E.....4312 E. 10th St. (1)
Banks, Horace M. (S)
3631 Forest Manor Ave. (18)
Baptisti, Arthur, Jr.
Marion Co. General Hospital (7)
Barry, Maurice J. (S)....501 Doctors' Bldg. (4)
Bartle, James L.....7450 Pendleton Pike (26)
Bartley, Max D.....607 Hume Mansur Bldg. (4)
Barton, David M.....I. U. Medical Center (7)
Bastnagel, William F...3602 N. Meridian St. (8)
Bates, Laurence H.....I. U. Medical Center (7)
Batman, Gordon W.....1815 N. Capitol Ave. (2)
Battersby, J. Stanley....I. U. Medical Center (7)
Batties, Paul A.....2142 N. Capitol Ave. (2)
Bauer, Thomas B....408 Hume Mansur Bldg. (4)
Baumeister, Herbert E...1815 N. Capitol Ave. (2)
Baxter, John P.....1633 N. Capitol Ave. (2)

Beach, Robert R.
5810 E. Pleasant Run Pkwy., N. Dr. (19)
Beamer, Parker R.....I. U. Medical Center (7)
Beaver, Howard W.....8 E. Troy (3)
Beck, Evart M.....915 E. 38th St. (5)
Becker, Harry G.....6060 College Ave. (20)
Beeler, John W.....Methodist Hospital (7)
Beeler, Raymond C. (S)
712 Hume Mansur Bldg. (4)
Belshaw, George.....1640 N. Ritter Ave. (18)
Belt, James H.....6225 Broadway (20)
Benedict, Paul F.....3941 Meadows Dr. (5)
Bennett, Ivan F.
Lilly Clinic, Marion Co. General Hospital (7)
Berman, Edward J. ..920 Hume Mansur Bldg. (4)
Berman, Jacob K.....920 Hume Mansur Bldg. (4)
Berner, Herbert W., Jr...I. U. Medical Center (7)
Berry, John M.....7841 White River Dr. (40)
Beverland, Malon E. (S)
3036 E. Washington St. (1)
Bibler, Lester D.....1815 Capitol Ave. (2)
Bill, Robert O.....2901 N. Meridian St. (8)
Black, Henry R..Marion Co. General Hospital (7)
Blackford, Florence.....5909 E. 10th St. (19)
Blackford, Ralph E. (S)....5909 E. 10th St. (19)
Blackwell, Donald S.....1815 N. Capitol Ave. (2)
Blake, Albert L.....1802 N. Illinois St. (2)
Blatt, A. Ebner.....3400 N. Meridian St. (8)
Bloemker, Edward F.....2729 Shelby St. (3)
Boggs, Eugene F.....2901 N. Meridian St. (8)
Boling, Frederick F.....3049 S. Holt Rd. (41)
Boling, Grover C.....1440 E. 46th St. (5)
Bomalaski, M. Donald..St. Vincent's Hospital (7)
Bond, George S. (S)....1221 N. Delaware St. (2)
Bond, Virginia.....R. R. 17, Box 364 (23)
Bond, William H.....I. U. Medical Center (7)
Bonsett, Charles A...902 Hume Mansur Bldg. (4)
Booher, Norman R.....447 E. 38th St. (5)
Booher, Olga Bonke.....447 E. 38th St. (5)
Booker, Harold E.....4901 Norwaldo (5)
Booth, Boynton H...707 Hume Mansur Bldg. (4)
Bowers, John A.....I. U. Medical Center (7)
Bowman, George W. (S)....1101 W. 10th St. (7)
Boyer, Floyd A.....442 N. Drexel Ave. (1)
Brady, Thomas A.....1815 N. Capitol Ave. (2)
Brayton, John R., Sr...704 Underwriters Bldg. (4)
Brayton, Lee.....3930 N. Illinois St. (8)
Brickley, Harry D...605 Hume Mansur Bldg. (4)
Brickley, Richard A..605 Hume Mansur Bldg. (4)
Briggs, Robert W.....2140 N. Capitol (2)
Brillhart, James R.....1640 N. Ritter Ave. (18)
Brodie, Donald W.....817 C. of C. Bldg. (4)
Brooks, Fred R., Jr.....3349 Georgetown Rd. (24)
Brown, Archie E.....1220 S. Belmont Ave. (21)
Brown, David E.....1944 N. Capitol Ave. (2)
Brown, DeWitt W.....1633 N. Capitol Ave. (2)
Brown, Frances T.....2126 N. Talbot Ave. (2)
Brown, Frank M.....2875 Clifton (23)
Brown, Gordon T.....3989 Meadows Drive (5)
Brown, Wendell E.....3426 N. Meridian St. (8)
Browning, James S.....3120 N. Meridian St. (8)
Browning, William M...3426 N. Meridian St. (8)
Brownley, E. Jane..2840 N. High School Rd. (24)
Bruce, Reginald A.....848 Indiana Ave. (2)
Brueckman, F. Robert
1815 N. Capitol Ave. #401 (2)
Bruetsch, Walter L..3000 W. Washington St. (22)
Burdette, Harold F.....3202 N. Meridian (8)
Burghard, Rolla D.....4829 E. 38th St. (18)
Butler, John O.....234 E. Southern Ave. (25)
Butler, Robert M.....3426 N. Meridian St. (8)

C

Cahn, Hugo M.....418 E. 30th St. (5)
Cahn, Peter H.....315 Hume Mansur Bldg. (4)
Caldwell, Marilyn R.....111 E. 53rd St. (20)
Call, Herbert F.....2901 N. Meridian (8)
Call, William H.....1815 N. Capitol Ave. (2)
Campbell, H. Edwin, Jr.,
418 Hume Mansur Bldg. (4)
Campbell, John A.....I. U. Medical Center (7)
Campbell, Robert L.....1100 W. Michigan St. (7)
Canaday, James W. (S)....1229 Prospect St. (3)
Cantwell, Edgar R.....I. U. Medical Center (7)
Caplin, Irvin.....1815 N. Capitol Ave. (2)
Caplin, Samuel S.....4525 Indianola, #3 (5)
Carson, Wayne.....1802 N. Illinois St. (2)
Carter, James E.....I. U. Medical Center (7)
Carter, Oren E.....668 E. 38th St. (5)
Cast, William R.....Methodist Hospital (7)
Chattin, William R.....4829 E. 38th St. (18)
Chen, Ko Kuei.....I. U. Medical Center (7)
Chernish, Stanley M.
Marion Co. General Hospital (7)
Chevalier, Robert B. 6834 Mohawk Lane (20)
Childress, Richard H....I. U. Medical Center (7)
Chivington, Paul V...407 Hume Mansur Bldg. (4)
Chroniak, Walter.....41 N. Shortridge Rd. (19)
Clark, Charles M., Jr.....I.U. Medical Center (7)
Clark, George A.....922 Hume Mansur Bldg. (4)
Clark, Lawson J.....3736 N. Delaware St. (5)
Clevinger, William G.....1601 N. Whitcomb (24)
Close, W. Donald.....I. U. Medical Center (7)
Coates, Jacqueline.....305 W. 42nd St. (8)
Coggeshall, Warren E...3524 N. Meridian St. (8)
Cohn, Alvin F.....1120 Southview Dr. (27)
Collins, Hubert L.....985 N. Arlington Ave. (19)
Collins, Robert C.....1356 W. 21st St. (2)
Conley, Joseph L. (S).....405 E. 52nd St. (5)
Conway, Chester C.....4402 E. New York St. (1)
Conway, Glenn.....1620 S. East St. (25)
Cookson, Lawrence U... I.U. Medical Center (7)
Cornacchione, Matthew.....814 S. East St. (25)
Cortese, James V.....435 S. East St. (25)
Cortese, Thomas A.....435 S. East St. (25)
Costin, Robert L.....301 E. 38th St. (5)
Coughenour, J. Robert....2809 S. Holt Road (41)
Countryman, Frank W...1815 N. Capitol Ave. (2)
Craft, Kenneth L. (S)
1002 Hume Mansur Bldg. (4)
Crawford, John A...321 Hume Mansur Bldg. (4)
Cronin, H. Joseph.....6951 College Ave. (20)
Cross, David G.....1002 Troy Ave. (3)
Culbertson, Clyde G.
Eli Lilly & Co., 740 S. Alabama St. (6)
Cullen, P. Kent, Jr.....310-11 Hume Mansur Bldg. (4)
Cullen, Paul K., Sr.....310-11 Hume Mansur Bldg. (4)
Culloden, William G. (S).....710 E. 46th St. (5)
Cunningham, Gene C.
Eli Lilly & Co., 740 S. Alabama St. (6)
Cure, Charles W.....1815 N. Capitol Ave. (2)
Currie, Robert W.....512 E. 57th St. (20)
Curry, R. Louis 3375 Forest Manor (18)
Cuthbert, Marvin P.....3400 N. Meridian (8)
Czenkusch, Helen G.....2840 High School Rd. (24)

D

Daley, Edward H.....5470 E. 16th St. (18)
Dallas, Fred R.....1640 N. Ritter Ave. (18)
Dallas, Mary E.
V. A. Hospital, 1481 W. 10th St. (7)
Dalton, William W...422 Hume Mansur Bldg. (4)
Daly, Joseph M.....234 E. Southern Ave. (25)
Daniel, John C. (S)....1008 Hume Mansur Bldg. (4)
Davidson, Dale A.....1815 N. Capitol Ave. (2)
Davidson, N. Cort.....3233 N. Meridian St. (8)
Davis, Bennie L.....2426 Northwestern Ave. (23)
Davis, F. Sterling.....922 Hume Mansur Bldg. (4)
Davis, Margaret M.....2603 W. 42nd St. (8)
Davis, Sam J.....908 Hume Mansur Bldg. (4)
Deal, Eleanor H..4909 W. 15th St., Speedway (24)
Dearmin, Robert M.....3233 N. Meridian St. (8)
DeArmond, Murray.....1815 N. Capitol Ave. (2)

Deever, John W.....4131 Shelby St. (27)
Dehner, John R.....I. U. Medical Center (7)
Deitch, Robert D.....4212 Carrollton Ave. (5)
Dennison, Alfred D., Jr...1815 N. Capitol Ave. (2)
Denny, Forrest L.....3351 W. 10th St. (22)
Denny, James W.....25 N. Ritter Ave. (19
DeWees, Dwight L.....302 N. Bradley Ave. (1)
DeWester, Gerald M.....3037 S. Meridian St. (27)
Dickson, Carolyn L.....501 N. West St. (2)
Dill, Myron K.....3120 N. Meridian St. (8)
Dilts, Robert L.....2521 E. 38th St. (18)
Dintaman, Paul G...703 Hume Mansur Bldg. (4)
Dolan, Patrick A.....Methodist Hospital (7)
Donato, Albert M.....1429 Shelby St. (3)
Doran, J. Hal.....620 Hume Mansur Bldg. (4)
Doughty, Samuel R., Jr.....5470 E. 16th St. (18)
Douglas, William T.....I. U. Medical Center (7)
Dowd, Joseph A. 6177 College Ave. (20)
Drew, Arthur L., Jr.....I. U. Medical Center (7)
Dryden, Gale E.....5835 N. Tacoma (20)
Duncan, Stuart J.....3037 S. Meridian St. (27)
Duncan, William A.....1221 E. 86th St. (40)
Dunkin, Ramon S.....I. U. Medical Center (7)
Dupes, Lowell E.
V. A. Regional Office, 36 S. Penn. St. (9)
Dupler, Lee F.....4310 Arcadia (24)
Dyar, Edwin W.....1010 E. 86th St. (40)
Dyke, Richard W. Marion Co. General Hospital (7)
Dyken, Mark L.....I. U. Medical Center (7)
Dzenitis, Andrievs J.....I. U. Medical Center (7)
Dziabis, Marvin D.....Methodist Hospital (7)

E

Earp, Evanson B.....717 Hume Mansur Bldg. (4)
Eastman, Joseph R., Jr.....220 W. 64th St. (8)
Eaton, Edwin R.....5505 N. Keystone Ave. (20)
Eaton, Lyman D.....5505 N. Keystone Ave. (20)
Ebert, J. Wayne.....1125 Southview Dr. (27)
Eberwein, John H. (S).....2322 Wheeler Ave. (18)
Echt, Charles R.....I.U. Medical Center (7)
Egan, Robert L.....Methodist Hospital (7)
Egbert, Herbert L.....5317 E. 16th St. (18)
Eicher, Palmer O.....3400 N. Meridian St. (8)
Eikenberry, Hugh W...616 Bankers Trust Bldg. (4)
Eldridge, Gail E.....1440 E. 46th St. (5)
Elkins, James P.....234 E. Southern Ave. (25)
Ellis, William N.....1640 N. Ritter Ave. (18)
Emhardt, John T.....1628 S. East St. (25)
Emhardt, John W. A. (S)
5424 Washington Blvd. (20)
Evans, Daniel R.....I.U. Medical Center (7)
Evans, Frederick H.....2140 N. Capitol (2)
Evans, Paul V...Marion Co. General Hospital (7)
Everly, Ralph V.....668 E. 38th St. (5)

F

Failey, Robert B.....I. U. Medical Center (7)
Farrell, Joseph T.....2807 E. Michigan St. (1)
Fausset, C. Basil.....2901 N. Meridian St. (8)
Feeney, Martin T.....St. Vincent's Hospital (7)
Ferry, Francis A.....1638 E. Raymond St. (3)
Finneran, Joseph C.....1802 N. Illinois St. (2)
Fisch, Charles.....I. U. Medical Center (7)
Fischer, A. Alan.....1745 Howard St. (21)
Fisher, Noreen M.....5775 E. Susan Dr. (50)
Fitzgerald, William J.
303 Fountain Square Theatre Bldg. (3)
Flanagan, Paul M.....3311 N. Meridian St. (8)
Flanders, Robert.....3202 N. Meridian St. (8)
Flanigan, Meredith B.....3305 Rutledge (8)
Fleischl, Herbert....Central State Hospital (22)
Flick, John J.....1443 N. Pennsylvania St. (2)
Flora, Joseph O....4317 W. Washington St. (21)
Folkening, Norval C...234 E. Southern Ave. (25)
Forbes, Robert S.....3049 S. Holt Rd. (41)
Forry, Frank (S).....I.U. Medical Center (7)
Fortuna, Frank W.....5602 S. Madison Ave. (27)
Fosgate, Harold L.....4301 E. 38th St. (18)
Foster, Lee N.....St. Vincent's Hospital (7)
Foster, Ray D.....1944 N. Capitol Ave. (2)
Fouts, Paul J.....623 Hume Mansur Bldg. (4)
Franklin, William L..508 Hume Mansur Bldg. (4)
Freed, Carl A.....2948 Kessler Blvd., N. Dr. (22)
Freeman, Leslie W.....I. U. Medical Center (7)
Freeman, Max E.....1745 Howard St. (21)
French, Richard N..LaRue D. Carter Hospital (7)
Fromhold, Willis A...611 Bankers Trust Bldg. (4)
Fry, Robert D.....517 Hume Mansur Bldg. (4)
Fulton, William H.....1934 Remington Dr. (27)
Funkhouser, Elmer (S)
702 Underwriters Bldg. (4)

G

Gabovitch, Edward R.....401 E. 34th St. (5)
Gaddy, Euclid T....2602 W. Washington St. (22)
Gaddy, Nelson D...2602 W. Washington St. (22)
Galloway, John A.....Eli Lilly & Co., 740 S. Alabama St. (6)
Gambill, J. Randolph
LaRue D. Carter Hospital (7)
Gambill, William D.....1633 N. Capitol Ave. (2)
Gammieri, Robert L.....661 E. 49th St. (5)
Garber, J. Neill.....1815 N. Capitol Ave. (2)
Garceau, George J....508 Hume Mansur Bldg. (4)
Gard, Daniel A..Ford Motor Co., Box 19106 (19)
Gardiner, Sprague H.....I. U. Medical Center (7)
Gardner, Austin L.....3400 N. Meridian St. (8)
Gardner, Buckman....St. Vincent's Hospital (7)
Garfield, Martin D.....3705 College Ave. (5)
Garner, W. Stanley.....2704 E. 62nd St. (20)
Garrett, John D. (S)....402 N. Meridian St. (4)
Garrett, Robert A.....I. U. Medical Center (7)
Geider, Roy A.....1525 Prospect St. (3)
Genna, Mary E. Miller.I. U. Medical Center (7)
George, Charles L.....1121 E. 80th St. (20)
Gibson, Greta Maxine
5744 Broadway Terrace (20)
Gick, Herman H. (S)..2705 E. Michigan St. (1)
Gifford, Fred E.....710 Hume Mansur Bldg. (4)
Gillespie, Charles F.....3400 N. Meridian St.
Gillespie, Jacob E...523 Hume Mansur Bldg. (4)
Gillim, Parvin D.....I. U. Medical Center (7)
Ginsberg, Stewart T.
LaRue D. Carter Hospital (7)
Glendening, John L. (S)
7202 N. Meridian St. (20)
Glover, John L.....3031 N. Centennial (22)
Godwin, Donald W.....Methodist Hospital (7)
Goldman, Samuel..2117 W. Washington St. (21)
Gooding, Richard A.....I. U. Medical Center (7)
Gormley, Joseph J.....2327 Lafayette Rd. (22)
Gosman, James H.....2901 N. Meridian St. (8)
Graham, Edward W.
V. A. Hospital, 1481 W. 10th St. (7)
Graham, John D.....1802 N. Illinois St. (2)
Gray, Kenneth L...2727 N. High School Rd. (24)
Grayson, Ted L.....1815 N. Capitol Ave. (2)
Green, Morris.....Riley Hospital (7)
Greene, Morgan E.....1621 S. East St. (25)
Gregory, Robert L.....1743 Shelby St. (3)
Greist, John H.....2901 N. Meridian St. (8)
Griffin, Leslie W.
Allison Div., General Motors, Box 894 (6)
Griffith, Richard S.
Lilly Clinic, Marion Co. General Hospital (7)
Griffith, Ross E.....401 E. 34th St. (5)
Grimes, Hubert N.....Methodist Hospital (7)
Grisell, Ted L.....5317 East 16th St. (18)
Grosz, Hanus J.....I. U. Medical Center (7)
Gruber, Charles M.
Lilly Clinic, Marion Co. General Hospital (7)
Gumbert, Jack L.
Marion Co. General Hospital (7)

H

Habegger, Elmer D.....1815 N. Capitol Ave. (2)
Hade, Frederick L. (S)
8925 W. Washington St. (31)
Hadley, David 702 Hume Mansur Bldg. (4)

Haggard, Edmund B..5914 N. Emerson Ave. (20)
Hall, Frank M.....100 N. Senate Ave. (4)
Hall, Jack H.....Methodist Hospital (7)
Hamer, Homer G. (S)..1711 N. Capitol Ave. (7)
Hamilton, Howard B....764 S. Emerson Ave. (3)
Hampshire, Donald R.
1443 N. Pennsylvania St. (2)
Hancock, John G.....2226 W. Michigan St. (22)
Hann, Eldon C.....1633 N. Capitol Ave. (2)
Hanna, Thomas A.....1608 N. Lynhurst Dr. (24)
Hansell, Robert M...6049 E. Washington St. (1)
Harcourt, Allan K.....812 C. of C. Bldg. (4)
Harcourt, Robert S.
Marion Co. General Hospital (7)
Harding, M. Richard.308 Hume Mansur Bldg. (4)
Harding, Myron S...308 Hume Mansur Bldg. (4)
Hare, Earl H. (S)
Indiana State Board of Health,
1330 W. Michigan St. (7)
Hare, Laura.....404 Hume Mansur Bldg. (4)
Harger, Robert W... 804 Hume Mansur Bldg. (4)
Harris, Carl B. 319 Hume Mansur Bldg. (4)
Harvey, Verne K., Jr.
Indiana State Board of Health,
1330 W. Michigan St. (7)
Haslinger, Clarence J...5236 Boulevard Pl. (8)
Hatfield, Jack J.....5538 N. Keystone Ave. (20)
Hatfield, Nicholas W.....5851 E. 54th Pl. (26)
Hawk, James H.....3736 N. Delaware St. (5)
Haymond, Joseph L.....301 E. 38th St. (5)
Haynes, John T.....1815 N. Capitol Ave. (2)
Hays, Everett L.....2607 Manker Ave. (3)
Healey, Robert J.....3602 N. Meridian St. (8)
Hedrick, Philip W.....1221 E. 86th St. (40)
Heimburger, Robert F...I. U. Medical Center (7)
Helmen, Charles H.....I. U. Medical Center (7)
Henderson, Francis G.
Eli Lilly & Co., 740 S. Alabama St. (6)
Henderson, Roscoe C.
3131 Northwestern Ave. (23)
Henderson, William P.
520 Hume Mansur Bldg. (4)
Hendricks, Fred A...6921 N. Keystone Ave. (20)
Hendricks, John W...911 Hume Mansur Bldg. (4)
Henry, Russell S.....725 Hume Mansur Bldg. (4)
Hepburn, C. K.....1633 N. Capitol Ave. (2)
Hetherington, John A..1633 N. Capitol Ave. (2)
Heubi, John E.....668 E. 38th St. (5)
Hibner, Dan W.....215 E. New York St. (4)
Hickam, John B.....I. U. Medical Center (7)
Hickman, Jack W.
Marion Co. General Hospital (7)
Hickman, Walter F. (S)..1210 Oliver Ave. (21)
Hicks, Murwyn L.....5470 E. 16th (18)
Hicks, Wilbur P.....310 W. 40th St. (8)
Hieber, Frank R.....3120 N. Meridian St. (8)
Hildebrand, William L..2963 N. Sherman Dr. (18)
Hill, Herbert N.....Methodist Hospital (7)
Hill, James K.....4701 W. 30th St. (24)
Hill, Morris R...Marion Co. General Hospital (17)
Himler, James M.....809 Underwriters Bldg. (4)
Hines, Don C.
Eli Lilly & Co., 740 S. Alabama St. (6)
Hodges, Fletcher (S).....3160 N. Penn. St. (5)
Hoffman, Herman.....650 E. 38th St. (5)
Hofmann, J. William (S)
8360 Washington Blvd. (40)
Hogan, Michael A.....6214 Broadway (20)
Holland, William M.....I. U. Medical Center (7)
Holman, Jerome E., Jr.....3315 E. 10th St. (1)
Holman, Jerome E., Sr. (S)..3315 E. 10th St. (1)
Holmes, George H., Jr.
313 Hume Mansur Bldg. (4)
Hood, Ainslee A.....3205 Shelby St. (27)
Horwitz, Thomas....421 Hume Mansur Bldg. (4)
Howell, Arthur.....305 W. 42nd St. (8)
Howell, Joseph D...760 Bankers Trust Bldg. (4)
Hoyt, Lester H.....Methodist Hospital (7)
Hoyt, Millard L.....612 Hume Mansur Bldg. (4)
Hubbard, Jesse D.....I. U. Medical Center (7)
Huber, Carl P.....I. U. Medical Center (7)
Hudson, Foster J.....3440 N. Meridian St. (8)
Hull, DeWayne L.....I. U. Medical Center (7)
Hull, Ronald H.....1815 N. Capitol Ave. (2)
Hummons, Francis D.
2229 Northwestern Ave. (23)
Hunt, H. Richard.....I. U. Medical Center (7)
Hurteau, William W.....Methodist Hospital (7)
Huse, William M.....1815 N. Capitol Ave. (2)

I

Irvine, William O.
V. A. Hospital, 1481 W. 10th St. (7)
Irwin, Glenn W., Jr.....I. U. Medical Center (7)
Iske, Paul G.....420 Hume Mansur Bldg. (4)

J

Jackson, James W. (S).....463 W. 32nd St. (8)
Jaeger, Alfred S. (S).3057 Washington Blvd. (5)
James, Charles E.....6939 N. Michigan Rd. (68)
Jaquith, Orville S. (S) ..261 Blue Ridge Rd. (8)
Jay, Arthur N.....3400 N. Meridian St. (8)
Jay, James M.....1633 N. Capitol Ave. (2)
Jenkins, Robert E.....3311 N. Meridian St. (8)
Jennings, Frank L. (S)
V. A. Hospital, 1481 W. 10th St. (7)
Jewett, Joe H.....3120 N. Meridian St. (8)
Jobes, James E.....110 N. Illinois St.,#413 (4)
Johnson, Earl H.....1802 N. Illinois St. (2)
Johnson, Thomas W.....1802 N. Illinois St. (2)
Jones, Allen W.....6060 College Ave. (20)
Jones, David E.....828 C. of C. Bldg. (4)
Jones, Francis P.....4212 E. Michigan St. (1)
Jones, George L.....8933 Southeastern Ave. (19)
Jones, Gordon C.....1517 N. Emerson (19)
Jontz, Jon P.....I. U. Medical Center (7)
Joseph, Rex M.....59 E. Troy St. (3)
Jowitt, Richard H.....1502 N. Emerson (19)
Judd, Russell L.....5470 E. 16th St. (18)
Judson, Walter E.....I. U. Medical Center (7)

K

Kahler, Maurice V.....2638 Kessler Blvd. (22)
Kahn, Alexander J.....3120 N. Meridian St. (8)
Kahn, Howard L.....3120 N. Meridian St. (8)
Kaiser, James L.....1815 N. Capitol Ave. (2)
Kalb, Everett L.....5934 E. 21st St. (18)
Kalsbeck, John E.....I. U. Medical Center (7)
Kammen, Leo.....3202 W. 16th St. (22)
Karsell, William A.....3989 Meadows Dr. (5)
Katterjohn, James C..313 Hume Mansur Bldg. (4)
Kauffman, Nelson N....2901 N. Meridian St. (8)
Kebel, Arthur P.....4456 N. Keystone Ave. (5)
Keenan, George B.....3225 Shelby St. (27)
Keever, Charles H.....5214 College Ave. (20)
Keiser, Venice D. (S).....5709 Broadway (20)
Kelly, Don E.....702 Underwriters Bldg. (4)
Kennedy, Hunter F.....1229 Prospect St. (3)
Kennedy, Joseph T.....5470 E. 16th St. (18)
Kenney, David B.....I. U. Medical Center (7)
Kenzler, Jack I.....205 Hume Mansur Bldg. (4)
Kerr, Harry R.....2817 E. Washington St. (1)
Ketcham, Jane M. (S).....3906 Ruckle St. (5)
King, Harold.....I. U. Medical Center (7)
King, William E.....811 Hume Mansur Bldg. (4)
Kingsbury, John K. (S)
5462 E. Washington St. (19)
Kinzel, Robert J. W.....3120 N. Meridian St. (8)
Kirkhoff, Paul J.....5317 E. 16th St. (18)
Kirklin, Oren L.....1802 N. Illinois St. (2)
Kirtley, William R.
Eli Lilly & Co., 740 S. Alabama St.
Kissel, Wesley A.....1815 N. Capitol Ave. (2)
Kitterman, Harry E.....5317 E. 16th St. (18)
Klain, Benjamin V.....4157 College Ave. (5)
Klepinger, Carol A.....Methodist Hospital (7)
Klutinoty, George II..St. Vincent's Hospital (7)
Kneidel, John H.....508 E. 38th St. (5)
Knowles, Charles Y.....5317 E. 16th St. (18)

Knowles, Robert P.
2948 Kessler Blvd., N. Dr. (22)
Kohlstaedt, Karl C.
Eli Lilly & Co., 740 S. Alabama St. (6)
Kohlstaedt, Kenneth G.
Eli Lilly & Co., 740 S. Alabama St. (6)
Kooiker, John E.....1815 N. Capitol Ave. (2)
Koons, Karl M. (S).923 Hume Mansur Bldg. (4)
Kopecky, Robert R.....4131 Shelby St. (27)
Kornafel, L. H.....905 Hume Mansur Bldg. (4)
Kraft, Bennett.....760 Bankers Trust Bldg. (4)
Kremp, Richard E.....6939 N. Michigan Rd. (68)
Kriel, William B....5630 W. Washington St. (21)
Kuntz, Herman W...611 Hume Mansur Bldg. (4)
Kurtz, Fred B. (S).....5520 N. Illinois St. (8)
Kurtz, Philip L.
Eli Lilly & Co., 740 S. Alabama St. (6)
Kwitny, Isadore J.....3400 N. Meridian St. (8)

L

LaDine, Clarence B.....2508 Station St. (18)
Lamb, Emmett B.....205 Hume Mansur Bldg. (4)
Lamb, Russell W.....205 Hume Mansur Bldg. (4)
Lamber, Chet K.....914 Hume Mansur Bldg. (4)
Lamkin, E. Henry, Jr...5525 N. Delaware St. (20)
Landwehr, Alfons.....Sunnyside Sanitorium (26)
Lane, C. Elaine.....2840 N. High School (24)
Lang, Erich K.....Methodist Hospital (7)
Lang, Jay W.....Marion Co. General Hospital (7)
Largaespada, Manuel.....812 C. of C. Bldg. (4)
Lashmet, Michael H..419 Hume Mansur Bldg. (4)
Lasich, Anthony R.....820 C. of C. Bldg. (4)
Lawrance, Kingsley
Marion Co. General Hospital (7)
Lawson, Allan J.....1010 E. 86th St. (40)
Leasure, J. Kent (S)...3060 N. Meridian St. (8)
Leatherman, Harter L.....1531 Broadway (2)
Leffel, James M.....1633 N. Capitol Ave. (2)
Leffler, William T.....2141 E. 52nd St. (5)
LeMaster, Theodore R.
305 Hume Mansur Bldg. (4)
Leser, Ralph U.....3233 N. Meridian St. (8)
Levi, Leon.....40 W. 38th St. (8)
Levin, Ralph T.....3400 N. Meridian St. (8)
Lewis, Paul S.....6357 Rockville Rd. (24)
Lewis, R. Earl.....2307 E. Raymond St. (3)
Ley, Glen D.....Methodist Hospital (7)
Lichtenberg, Melvin.....535 E. 38th St. (5)
Lidikay, Edward C.....3989 Meadows Dr. (5)
Lindenborg, Paul G..3016 N. Arlington Ave. (18)
Lingeman, Raleigh E...1944 N. Capitol Ave. (2)
Lingeman, Roger E...2081 N. Emerson Ave. (18)
Link, Goethe (S).....401 N. Illinois St. (4)
Littlefield, Paul A.
4040 Crooked Creek Overlook (8)
Littlefield, Shirley D.....1815 N. Capitol Ave. (2)
Lloyd, Frank P.....Methodist Hospital (7)
Loehr, William M.....I. U. Medical Center (7)
Loomis, Norman S.....5230 N. Kenwood Ave. (8)
Lord, Glenn C.....104 E. 38th St. (5)
Louden, Robert W.....1221 E. 86th St. (40)
Loughlin, L. Leo.....1815 N. Capitol Ave. (2)
Love, George N.....5331 Washington Blvd. (20)
Lozow, David.....3941 Meadows Dr. (5)
Lucas, Clarence A., Jr....2012 Boulevard Pl. (2)
Lukemeyer, George T....I. U. Medical Center (7)
Lunsford, Thomas E....1815 N. Capitol Ave. (2)
Lurie, Paul R.....I. U. Medical Center (7)
Luros, J. Theodore.....1633 N. Capitol Ave. (2)
Lybrook, William B...3731 N Keystone Ave. (18)
Lynn, Gene E.....1815 N. Capitol Ave. (2)

M

MacDougall, John D.....3941 Meadows Dr. (5)
McAlpine, Richard J..5704 N. Keystone Ave. (20)
McAree, Francis E.....5470 E. 16th St. (18)
McBride, James S. (S).....720 E. 80th St. (40)
McCallum, Donald C.....1815 N. Capitol Ave. (2)
McCallum, Joseph T. C. (S)..237 W. 46th St. (8)
McCallum, Robert N....1906 N. Capital Ave. (2)
McCartney, Donald H.
1021 Hume Mansur Bldg (4)
McClain, Edwin S...414 Hume Mansur Bldg. (4)
McCormick, Charles O., Jr..3989 Meadows Dr. (5)
McGrath, Michael F.....1929 E. 38th St. (18)
McIntyre, Charles J. (S).3930 Carrollton Ave. (5)
McIntyre, James M.....2901 N. Meridian St. (8)
McKinley, A. David.....I. U. Medical Center (7)
McLaren, Daniel E.....6000 E. 46th St. (26)
McQuiston, Ralph J.....608 Guaranty Bldg. (4)
McTurnan, Robert W.....5646 N. Illinois St. (8)
Mackey, Harry S. (S).....4309 Central Ave. (5)
Mackey, John E.....3400 N. Meridian St. (8)
Madden, Robert J.....4612 E. 10th St. (1)
Madtson, A. Ricks.1815 N. Capitol Ave. #307 (2)
Magennis, Herbert L. (S).8417 Compton Dr. (20)
Malcolm, Russell L., Jr.
I. U. Medical Center (7)
Manalan, Maurice M.
5831 E. Washington St. (19)
Manders, Karl L.....3400 N. Meridian (8)
Manion, Marlow W...601 Hume Mansur Bldg. (4)
Mann, Mortimer.....3426 N. Meridian St. (8)
Manning, K. Randolph..1815 N. Capitol Ave. (2)
Manzie, Michael W.....2372 Lafayette Rd. (22)
Marks, Maurice I.....2901 N. Meridian St. (8)
Markstone, David H.....I. U. Medical Center (7)
Marsh, Carl M.....101 N. Shortridge Rd. (19)
Marshall, Albert L., Jr.
Indiana State Board of Health,
1330 W. Michigan St. (7)
Marshall, Cavins R. (S) 43 W. 30th St. (8)
Martin, Hugh E.
Pitman-Moore Co., 1200 Madison Ave.
Martin, Loren H....2626 W. Washington St. (22)
Martz, Bill L.
Lilly Clinic, Marion Co. General Hospital (7)
Martz, Carl D.....912 Hume Mansur Bldg. (4)
Marvel, Robert J.....3426 N. Meridian St. (8)
Masters, John M.....805 Hume Mansur Bldg. (4)
Masters, Robert J...805 Hume Mansur Bldg. (4)
Matthew, W. Burleigh....518 Hume Mansur Bldg. (4)
Matthews, Bernard J.....4612 E. 10th St. (1)
Matthews, William M...1122 N. Bolton Ave. (19)
Maxam, B. T.....3524 N. Meridian St. (8)
Mealey, John, Jr.....I. U. Medical Center (7)
Megenhardt, Dennis S..1633 N. Capitol Ave. (2)
Meiks, Lyman T.....Riley Hospital (7)
Melin, John R.....1815 N. Capitol Ave. (2)
Mentendiek, Maurice H.
141 Buckingham Dr. (8)
Mericle, Earl W.....1633 N. Capitol Ave. (2)
Merritt, A. Donald.....I. U. Medical Center (7)
Merritt, Doris H.....I. U. Medical Center (7)
Mershon, Jack B.....3855 E. 10th St. (1)
Mertz, John H. O.....1711 N. Capitol Ave. (7)
Michael, Isaac E...2948 Kessler Blvd., N. Dr. (22)
Middleton, Harvey N.....1828 N. Illinois St. (2)
Millan, Felix....Marion Co. General Hospital (7)
Miller, Frank H.....201 Hume Mansur Bldg. (4)
Miller, Jerry A.....I. U. Medical Center (7)
Miller, Jerry R.....I. U. Medical Center (7)
Miller, John D.....Sunnyside Sanitorium (26)
Miller, Roscoe E.....I. U. Medical Center (7)
Mitchell, George H...6049 E. Washington St. (19)
Moak, Glenn D.....712 Hume Mansur Bldg. (4)
Moenning, John E.....3202 N. Meridian St. (8)
Montgomery, William F.
904 Hume Mansur Bldg. (4)
Moore, Donald F...LaRue D. Carter Hospital (7)
Moore, Harold T.....5802 Allisonville Rd. (20)
Moran, William J.....1927 E. 62nd St. (20)
Morchan, Samuel.....3769 College Ave. (5)
Morgan, Margaret E....3400 N. Meridian St. (8)
Moriarty, John R.....5602 Madison Ave. (3)
Morrison, Lewis E...603 Hume Mansur Bldg. (4)
Morton, Joseph L.....St. Vincent's Hosp. (7)

Morton, Walter P.....3434 Fall Creek Blvd. (5)
Moser, Rollin H.....3524 N. Meridian St. (8)
Moss, Bobby L.....1121 N. Arlington Ave. (19)
Moss, Harlan B.....1640 N. Ritter Ave. (18)
Moss, Herschel C.....1640 N. Ritter Ave. (18)
Mothersill, Mark H. (S)....3650 College Ave. (5)
Mouser, Robert W.....6201 Park Ave. (20)
Mullen, James B.....3120 N. Meridian St. (8)
Muller, Lullus P.....3120 N. Meridian St. (8)
Muller, Paul F.....3311 N. Meridian St. (8)
Muller, Victor H.....St. Vincent's Hosp. (7)
Mullican, William S.....I.U. Medical Center (7)
Myers, Charles W. (S)..R. R. 18, Box 256 (24)

N

Nagan, Robert F.....606 Hume Mansur Bldg. (4)
Nay, Richard M.....3524 N. Meridian St. (8)
Need, David J.....3243 S. Pennsylvania St. (27)
Need, Louis T.....1927 S. Meridian St. (25)
Nester, Henry G.....1841 City-County Bldg. (4)
Nicholas, Dennis J.....4365 Wexford (26)
Nie, Louis W.....2901 N. Meridian St. (8)
Nohl, John M.....457 N. Emerson Ave. (19)
Nolin, Richard T...LaRue D. Carter Hospital (7)
Nolting, Henry F. (S).....261 W. 40th St. (8)
Norman, William H...908 Hume Mansur Bldg. (4)
Norris, Max S.....510 Hume Mansur Bldg. (4)
Nourse, Myron H.....1711 N. Capitol Ave. (7)
Nugent, Edwin J...Allison Div. GMC, Box 894 (6)
Nurnberger, John I.....I. U. Medical Center (7)

O

O'Brian, Earl J.....3041 Lafayette Rd. (22)
Ochsner, Harold C.....3440 N. Meridian St. (8)
Offutt, Andrew C...Indiana State Board of Health, 1330 W. Michigan St. (7)
Olvey, Ottis N.....3769 Park Ave. (5)
Orders, Clark E. (S)
4954 W. 15th St., Speedway (24)
Otten, Claude F.....812 C. of C. Bldg. (4)
Overley, Ross A.....1815 N. Capitol Ave. (2)
Overley, Toner M., Jr.....I.U. Medical Center (7)
Owen, John E.....605 Hume Mansur Bldg. (4)
Owens, Tracy C.....2823 N. Meridian St. (8)

P

Palmer, Charman F.....3400 N. Meridian St. (8)
Palmer, Harley P.....Methodist Hospital (7)
Palmer, Robert M.....I. U. Medical Center (7)
Palmer, Robert W.....3400 N. Meridian St. (8)
Pantzer, John G., Jr.....I. U. Medical Center (7)
Parker, George F., Jr..1502 N. Emerson Ave. (19)
Parker, John F.....1706 E. Washington St. (1)
Parker, Portia.....2226 W. Michigan St. (22)
Parr, Robert L.....3043 E. 38th St. (18)
Paskind, Jacob..Marion Co. General Hospital (7)
Paulissen, George T.....741 Markwood Ave. (27)
Pearson, John S...American United Life Ins. Co., 30 W. Fall Creek Parkway (6)
Peck, Franklin B., Jr.
Lilly Clinic, Marion Co. General Hospital (7)
Peirce, James D.
Eli Lilly & Co., 740 S. Alabama St. (6)
Permer, Erwin....635 Kessler Blvd., E. Dr. (20)
Peterson, Deward D.
Marion Co. General Hospital (7)
Petranoff, Theodore V. (S)
515 N. Tibbs Ave. (22)
Pettijohn, Fred L. (S).....2460 Central Ave. (5)
Pfaff, Dudley A.
V.A. Regional Office, 36 S. Pennsylvania St. (9)
Phillips, David L.....3400 N. Meridian St. (8)
Pickett, Robert D.....3524 N. Meridian St. (8)
Pierce, Raymond O.....3151 N. Illinois St. (8)
Pilcher, Jack E.....1802 N. Illinois St. (8)
Poland, Maynard D.....Methodist Hospital (7)
Pontius, Edwin E.....Methodist Hospital (7)
Popplewell, Arvine G.
Marion Co. General Hospital (7)
Powell, Richard C.....I. U. Medical Center (7)
Price, Francis W.....1002 E. Troy Ave. (3)
Price, James O.....512 Hume Mansur Bldg. (4)
Price, Walter S.....8430 Washington Blvd. (20)
Pryor, Richard C.....6111 College Ave. (20)

Q

Quigley, Joseph B.....5470 E. 16th St. (19)

R

Rabb, Frank M.....915 E. 38th St. (5)
Rabb, Harry S.....3139 E. 10th St. (1)
Raber, Robert M.....1633 N. Capitol Ave. (2)
Rader, George S.....1815 N. Capitol Ave. (2)
Rafalski, Thomas A.....3120 N. Meridian St. (8)
Ragan, William D.....3400 N. Meridian St. (8)
Ralston, John D.....Central State Hosp. (22)
Ramsey, Frank B.....1802 N. Illinois St. (2)
Ransburg, Robert C.....Methodist Hospital (7)
Rawls, George H.....3151 N. Illinois St. (8)
Reed, Philip B.....1815 N. Capitol Ave. (2)
Reed, Thomas E.....6049 E. Washington St. (19)
Rees, Russel C.....6114 E. Washington St. (19)
Reid, Charles A.....2445 Shelby St. (3)
Reisler, Simon (S)..310 Bankers Trust Bldg. (4)
Rhamy, Robert K.....I. U. Medical Center (7)
Rice, Frederic A., Jr.....7017 Pendleton Pike (26)
Rice, Raymond D.....1010 E. 86th St. (40)
Rice, Raymond M.
Eli Lilly & Co., 740 S. Alabama St. (6)
Rice, Ronald B.....1010 E. 86th St. (40)
Richardson, Thad T.....513 S. Sherman Dr. (3)
Richter, Arthur B...720 Hume Mansur Bldg. (4)
Ridolfo, Anthony S.
Lilly Clinic, Marion Co. General Hospital (7)
Riner, Jack K.....5317 E. 16th St. (18)
Ritchey, James O.....608 Hume Mansur Bldg. (4)
Ritter, Wayne L.....404 Hume Mansur Bldg. (4)
Robb, John A.....238 Hume Mansur Bldg. (4)
Robertson, Ray B...6118 E. Washington St. (19)
Robinson, Earle U.....2416 N. Capitol Ave. (8)
Rochlin, Isidore.....3202 N. Meridian St. (8)
Roesch, Ryland P.....5444 N. Illinois St. (8)
Roeske, Nancy A.....220 W. Beverly Dr. (5)
Rogers, Donald L.....3426 N. Meridian St. (8)
Rohn, Robert J.....I. U. Medical Center (7)
Roll, John W.....3628 N. Sherman Dr. (18)
Roller, Charles W. (S).....915 Hervey (3)
Romberger, Floyd T., Jr..3440 N. Meridian St. (8)
Rosenak, Bernard D...226 Hume Mansur Bldg. (4)
Rosenbaum, Irving, Jr. 401 E. 34th St. (5)
Rosenberg, Gabriel J.....6450 W. 10th St. (24)
Ross, Alexander T.....I. U. Medical Center (7)
Roth, Bertram S.....6358 College Ave. (20)
Rougraff, Maurice E.
American United Life Ins. Co., 30 W. Fall Creek Parkway (6)
Row, D. Hamilton...906 Hume Mansur Bldg. (4)
Ruddell, Karl R. (S)...3202 N. Meridian St. (8)
Ruddell, Keith R.....3202 N. Meridian St. (8)
Rudesill, Cecil L. (S)
405 Hume Mansur Bldg. (4)
Rudesill, Robert L...405 Hume Mansur Bldg. (4)
Rupel, Ernest (S).....5735 N. Meridian St. (8)
Russell, John R.....1815 N. Capitol Ave. (2)
Rust, Roland B.....3939 Meadows Drive (5)
Ruth, Martin L.....4304 E. Washington St. (1)
Rutherford, Cyrus W. (S)
4601 N. Pennsylvania St. (5)
Ryan, C. David.....Methodist Hospital (7)
Ryan, Glen V.....2428 W. 16th St. (22)

S

Sage, Russell A.....1944 N. Capitol Ave. (2)
Salb, Max C.....823 C. of C. Bldg. (4)
Samter, Thomas G.....I. U. Medical Center (7)
Sanders, Fred.....6007 N. Michigan Rd. (8)
Sanders, Harry M. 4829 E. 38th St. (18)
Sanders, Marilyn M.....Methodist Hospital (7)
Saperstein, Morris....1815 N. Capitol Ave. (2)

Schaffer, Edward V.....1815 N. Capitol Ave. (2)
Schechter, John S.....3400 N. Meridian St. (8)
Scheier, Emil W.....1542 Prospect St. (3)
Schermer, Kenneth L.....Methodist Hospital (7)
Schlaegel, Theodore F., Jr.
I. U. Medical Center (7)
Schlegel, Donald M.....1815 N. Capitol Ave. (2)
Schmalhausen, Ansel W...1815 N. Capitol Ave. (2)
Schmidt, Loren F....605 Hume Mansur Bldg. (4)
Schmoyer, Maurice R...Community Hospital (19)
Schneider, Carl J.....1008 N. Beville Ave. (1)
Schneider, Paul A.....4829 E. 38th St. (18)
Schnute, Richard B.....I. U. Medical Center (7)
Schuchman, Abe.....3763 Broadway (5)
Schuchman, Gabriel.....3451 College Ave. (5)
Schuster, Dwight W.....1814 N. Capitol Ave. (2)
Schwarz, Anton
Pitman-Moore Co., 1200 Madison Ave. (6)
Scofield, John B.....3120 N. Meridian St. (8)
Scott, George E.....4110 Roland Rd. (8)
Scott, I. Winfield.....3400 N. Meridian St. (8)
Scott, John R.....6214 Broadway (20)
Scott, Robert P.....209 Hume Mansur Bldg. (4)
Scott, Samuel L.....6325 Guilford Ave. (20)
Seaman, Charles F...301 Hume Mansur Bldg. (4)
Searight, John L.....6032 E. 10th St. (19)
Sedam, Herbert L.....4548 College Ave. (5)
Segar, William E.....Riley Hospital (7)
Sellmer, George W.....1221 E. 86th St. (40)
Sexson, Hiram T.....3731 N. Keystone (18)
Seybert, Thomas C.....6000 E. 46th St. (26)
Shafer, Marion R...614 Hume Mansur Bldg., (4)
Shanafelt, Donald K.....1802 N. Illinois St. (2)
Shapiro, Burton J.....3620 N. Meridian St. (8)
Sheehan, Francis G..6049 E. Washington St. (19)
Shelley, Richard J.....5470 E. 16th St. (18)
Sherster, Harry.....1135 S. Meridian St. (25)
Shipley, Edward....LaRue D. Carter Hospital (7)
Shullenberger, Wendell A.
1815 N. Capitol Ave. (2)
Shumacker, Harris B., Jr.,
I. U. Medical Center (7)
Sicks, Okla W. (S).....607 E. 82nd St. (20)
Sidebottom, Earl W...507 Hume Mansur Bldg. (4)
Siderys, Harry.....3941 Meadows Dr. (5)
Siebe, Jack C.....4829 E. 38th St. (18)
Siersdorfer, Theodore N. (S)
5559 W. Morris St. (21)
Sigmond, Harvey W..321 Hume Mansur Bldg. (4)
Silver, Richard A.....712 Hume Mansur Bldg. (4)
Simmons, James E.....I. U. Medical Center (7)
Simms, J. Leon....2453 Northwestern Ave. (23)
Simpson, William D..6049 E. Washington St. (19)
Sims, J. Lawrence....3400 N. Meridian St. (8)
Singco, Bienvenido.....5202 N. Illinois St. (8)
Sisk, Phillip B.....I. U. Medical Center (7)
Slichenmyer, Jack E....1944 N. Capitol Ave. (2)
Slomka, Myron B.
Pitman-Moore Co., 1200 Madison Ave.,
P. O. Box 1656 (6)
Sluss, David H.....808 C. of C. Bldg. (4)
Smith, David L...2948 Kessler Blvd., N. Dr. (22)
Smith, E. Rogers (S).822 Hume Mansur Bldg. (4)
Smith, Francis C....1102 N. Irvington Ave. (19)
Smith, Roy Lee (S)...707 Underwriters Bldg. (4)
Snider, Byron.....2717 S. East St. (3)
Solomon, Reuben A. (S)
414 Hume Mansur Bldg. (4)
Soper, Hunter A.....3524 N. Meridian St. (8)
Souter, Martha C.....3360 N. Meridian St. (8)
Sovine, Joe W.....504 Hume Mansur Bldg. (4)
Spahr, John F.. Jr.,....3440 N. Meridian St. (8)
Spalding, Joseph J...706 Hume Mansur Bldg. (4)
Spangler, John S.....Methodist Hospital (7)
Sparks, Alan L.....1024 Hume Mansur Bldg. (4)
Spears, John M.....7046 Madison Ave. (27)
Speckman, Glenn H.....2120 E. 10th St. (1)
Spolyar, Louis W...Indiana State Board of Health,
1330 W. Michigan St. (7)
Sputh, Carl B., Jr.....301 Doctors' Bldg. (4)
Stadler, Harold E.....41 N. Shortridge Rd. (19)
Stander, Richard W.....I. U. Medical Center (7)
Stansbury, William E...3628 N. Sherman Dr. (18)
Stayton, Chester A., Jr.
313 Hume Mansur Bldg. (4)
Steinmetz, Edward F.
Marion Co. General Hospital (7)
Stephens, Donald E.....6332 Guilford Ave. (20)
Stephens, Kuhrman H.
501 Hume Mansur Bldg. (4)
Stevens, Sydney L....303 Hume Mansur Bldg. (4)
Stoelting, Vergil K.....I. U. Medical Center (7)
Stone, Alvin T.....6202 College Ave. (20)
Stonier, Peter F.....3213 E. 36th St. (18)
Storey, D. Edmund.....6225 Broadway (20)
Storey, Joseph L.....3454 N. Illinois St. (8)
Storms, Roy B. (S).....812 C. of C. Bldg. (4)
Strang, William C.....1815 N. Capitol Ave. (2)
Streeter, Ralph T.....3131 E. 38th St. (18)
Strickland, James W.
Marion Co. General Hosp. (7)
Strickland, Neil R.....6000 E. 46th St .(26)
Stucky, Elsworth K.....1349 Madison Ave. (25)
Stump, Loyd K.....3941 Meadows Dr. (5)
Stump, Thomas A.
Marion Co. General Hospital (7)
Suelzer, John G.....1815 N. Capitol Ave. (2)
Suess, Robert E.....41 N. Shortridge Rd. (19)
Sullivan, James J.....St. Vincent's Hospital (7)
Summerlin, Jack D.....I. U. Medical Center (7)
Surratt, Mary Norris.....1010 E. 86th St. (40)
Sutton, William E....521 Hume Mansur Bldg. (4)
Swan, John R.....915 Hume Mansur Bldg. (4)
Symmes, Alfred T.....625 E. 38th St. (8)
Szynal, John S.....633 E. 38th St. (5)

T

Takahashi, Masato.....I. U. Medical Center (7)
Talbott, Dan E.....1802 N. Illinois St. (2)
Tanner, Henry S.....321 Hume Mansur Bldg. (4)
Taube, Jack I.....214 Hume Mansur Bldg. (4)
Taylor, Clifford C.....Community Hospital (19)
Taylor, Frederic W.....3524 N. Meridian St. (8)
Teague, Frank W...1021 Hume Mansur Bldg. (4)
Teixler, Victor A.....224 Hume Mansur Bldg. (4)
Tepfer, Milton..Marion Co. General Hospital (7)
Test, Charles E.....1006 Hume Mansur Bldg. (4)
Teter, George V.....1221 E. 86th St. (40)
Tether, Joseph E.....510 Hume Mansur Bldg. (4)
Tharpe, Ray G.....3202 N. Meridian St. (8)
Thatcher, Hugh K., Jr....4548 College Ave. (5)
Thoman, Rex L.....I. U. Medical Center (7)
Thomas, Charles R.....4051 S. East St. (27)
Thomas, Edward P.....917 W. 30th St. (23)
Thomas, Fred A.....St. Vincent's Hospital (7)
Thomas, Lowell I.....1815 N. Capitol Ave. (2)
Thomas, Morris E.....1802 N. Illinois St. (2)
Thompson, John V.....7899 Ridge Rd. (20)
Thompson, Joseph F...6138 N. Hillside Ave. (20)
Thompson, Paul D.
423 Hume Mansur Bldg. (4)
Thompson, Wayne H.....5470 E. 16th St. (18)
Thornton, Harold C.....301 E. 38th St. (5)
Throop, Frank B.....3400 N. Meridian St. (8)
Timmons, Gerald D.....I. U. Medical Center (7)
Tindall, George T.....6002 Windsor Dr. (18)
Tinsley, Frank W.....3044 Lafayette Rd. (22)
Tinsley, Walter B., Jr....3044 Lafayette Rd. (22)
Tinsley, Walter B. (S)....603 K. of P. Bldg. (4)
Tischer, E. Paul.....208 Hume Mansur Bldg. (4)
Tofaute, John L.....Robert Long Hospital (7)
Tondra, John M.....400 Hume Mansur Bldg. (4)
Torrella, Jose A.....5324 W. 16th St. (24)
Toumey, Fred L.....1802 N. Illinois St. (2)
Townsend, James C.....I.U. Medical Center (7)
Trudgen, Spencer F....Methodist Hospital (7)
Trusler, H. Marshall...I. U. Medical Center (7)
Trusler, Harold M....408 Hume Mansur Bldg. (4)
Tuchman, Joseph H.....2040 E. 46th St. (5)

Tucker, Warren S...414 Hume Mansur Bldg. (4)
Tyler, Edward A.....I. U. Medical Center (7)
Tyner, Harlan H.....3202 N. Meridian St. (8)

U-V

Ullom, Ralph B.....3524 N. Meridian St. (8)
Van Denbark, Howard M..St. Vincent's Hosp. (7)
Vandivier, Robert M..209 Hume Mansur Bldg. (4)
Van Dorn, Myron J.....2165 Weslynn Dr. (8)
Van Fleet, Josephine....Indiana State Board of Health, 1330 W. Michigan St. (7)
Van Meter, C. Powell.....3419 E. 10th St. (1)
Van Tassel, Charles J. 709 Hume Mansur Bldg. (4)
Van Vactor, Helen D..226 Hume Mansur Bldg. (4)
Vellios, Frank.....I. U. Medical Center (7)
Vigor, David N.....Chrysler Corp., 2900 Shadeland Ave., (19)
Vollrath, Victor J.....5202 N. Illinois St. (8)
Von Der Haar, Gerard..4016 E. Michigan St. (1)
Vore, Robert E.....5470 E. 16th St. (18)

W

Wainscott, Clinton S.....804 C. of C. Bldg. (4)
Waldo, J. Thayer.....3989 Meadows Dr. (5)
Walters, Edward W.....I. U. Medical Center (7)
Walther, Joseph E.....3202 N. Meridian St. (8)
Walton, William M.....1802 N. Illinois St. (2)
Ward, Wesley C.....3 E. 46th St. (5)
Warman, Alvah P. (S)....1363 E. 38th St. (5)
Warneke, Charles H...St. Vincent's Hospital (7)
Warriner, James B...1012 N. Emerson Ave. (19)
Warvel, John H., Jr..614 Hume Mansur Bldg. (4)
Warvel, John H. (S)..614 Hume Mansur Bldg. (4)
Washington, Wilbert 2142 N. Capitol Ave. (2)
Wasserman, Don H.....I. U. Medical Center (7)
Wehrman, Jule O. (S) 1408 N. Pennsylvania St. (2)
Weigand, Clayton G. Eli Lilly & Co., 740 S. Alabama St. (6)
Weiss, Jason.....4914 W. 16th St. (24)
Weller, Charles A. (S)..3720 N. Delaware St. (5)
West, Joseph L.....6714 Rockville Rd. (41)
Westfall, B. Kemper.....2901 E. 38th St. (18)
Westfall, John B...1025 Hume Mansur Bldg. (4)
Wheeler, David E.....Community Hospital (19)
White, Donald J.....3524 N. Meridian St. (8)
White, Douglas H.....3524 N. Meridian St. (8)
White, John B., Jr.....1815 N. Capitol Ave. (2)
White, John P., Jr.....I. U. Medical Center (7)
Widdifield, G. E.....2614 Madison Ave. (3)
Wilkens, Irvin W.....1743 Shelby St. (3)
Williams, Charles D.....2422 Station St. (1)
Williams, Clifford L...Central State Hospital (22)
Williams, Harold W.....6000 E. 46th St. (26)
Williams, Howard S.....115 E. 16th St. (2)
Williams, Hugh L.....4829 E. 38th St. (18)
Williams, Paul D....Central State Hospital (22)
Wilmore, Ralph C. V. A. Hospital, 1481 W. 10th St. (7)
Wilson, Fred M.....I. U. Medical Center (7)
Wirey, Harold R.....6850 S. Madison Ave. (27)
Wise, William R.....2372 Lafayette Rd. (22)
Wishard, William N., Jr..1711 N. Capitol Ave. (7)
Witham, Robert L.....5740 E. 16th St. (18)
Woerner, Thomas E...620 Hume Mansur Bldg. (4)
Wolfram, Don J.....208 Hume Mansur Bldg. (4)
Wood, Donald E.....6325 Guilford Ave. (20)
Woodard, Abram S., Jr.....668 E. 38th St. (5)
Woolling, Kenneth R..718 Hume Mansur Bldg. (4)
Worley, Joseph P....5839 E. Washington St. (19)
Worley, Richard H.....5317 E. 16th St. (13)
Wrege, Malcolm L.....1502 N. Emerson Ave. (19)
Wright, James J.....1429 Shelby St. (3)
Wright, J. William, Jr. 301 Hume Mansur Bldg. (4)
Wyttenbach, John E...503 Hume Mansur Bldg. (4)

Y

Yacko, Michael L.....5470 E. 16th St. (18)
Yingling, Robert J.....Community Hospital (19)
Young, James W.....6302 Guilford Ave. (20)
Young, John E.....4829 E. 38th St. (18)
Young, John M.....1456 E. 46th St. (5)
Young, John T.....3151 N. Illinois St. (8)

Z

Zell, Evertson H.....812 C. of C. Bldg. (4)
Zeman, Ruth E.....3400 N. Meridian St. (8)
Zeps, E. Frances.....Indiana State Board of Health, 1330 W. Michigan St. (7)
Zerfas, Phyllis K.....R. R. 1, Box 220 (27)

Lewis, Robert J. 4350 Franklin Rd., Lawrence (26)
Steury, Ernest M. Box 949, World Gospel Mission, Marion
Peck, Franklin B., Sr.....R. R. 1, Monticello
Wilson, Oliver R.....Box 525, Morgantown
Montgomery, Ralph F..303 Wildwood Lane, Muncie
Asher, Ernest O. (S) 4730 W. 72nd St., New Augusta
Asher, James W...4730 W. 72nd St., New Augusta
Thurston, Harrison S. (S) P. O. Box 411, North Webster
Paynter, Morris B.....59 Union St., Southport
Anderson, John T.....Pitman-Moore Co., 9550 Zionsville Rd., Zionsville
Harvey, Verne K., Sr...R. R. 2, Box 354, Zionsville

Adams, Daniel S. (S) 2532 Columbus Dr., Ft. Myers, Fla.
Akre, Philip R...476 Prospect St., La Jolla, Calif.
Allen, Donald R. St. Louis City Hospital, St. Louis, Mo.
Baker, Charles R.....USPHS, Savannah, Ga.
Barden, Tom P.....507 USAF Hosp., Kincheloe AFB, Mich.
Barrett, Robert V.....10474 Janice Lynn Circle, Cypress, Calif.
Beer, Alan E.....USPHS Indian Hospital, Tuba City, Ariz.
Bohner, Caryle B.....Huasca, Hidalgo, Mexico
Borden, Tom P.....507 USAF Hospital, Kincheloe AFB, Mich.
Brayton, John R., Jr.....5664 Greenridge Rd., Castro Valley, Calif.
Breneman, William L.....8654 Paint Trail Ct., Fort Worth, Texas
Brose, Paul E.....RCA Bmews Project, Box 278, APO 23, New York, N. Y.
Bugh, Charles W.....1075 Riverview Dr., Fairbanks, Alaska
Close, Gerald A.....Mutambara Methodist Center, P. O. Mutambara, S. Rhodesia, Africa
Coddington, Robert C.....U. S. Army Hospital, Ft. Campbell, Ky.
Colbert, Richard M.....805 Alamanda Dr., Largo, Fla.
Colbert, Ruth E.....805 Alamanda Dr., Largo, Fla.
Cregger, Irby E.....1360 USAF Hospital, Orlando AFB, Fla.
Dirks, Kenneth R.....U. S. Army Medical Unit, Ft. Detrick, Md.
Donahue, James.....Rodriguez Army Hospital, APO 851, New York, N. Y.
Doss, Jerome F.....815 Medical Group, Forbes AFB, Kansas
Dyken, Paul R.....Washington University, St. Louis, Mo.
Eckberg, Theodore J.....U. S. Naval Hospital, Memphis 15, Tenn.
Fisher, Frank C.....379 Linwood Ave., Buffalo, N. Y.
Fisher, Gerald....Ippy, Central African Republic

Gabe, William E...61 Heather Lane, Orinda, Calif.
Gabrielsen, T. H.....%Salvation Army, A.P.O. 31, San Francisco, Calif.
Geisler, Hans E.....Memorial Hospital for Cancer & Allied Diseases, Sloan-Kettering Inst., New York, N. Y.
Gilliland, John E.....Gray Mem. Hosp., Puerto Cabezas, Nicaragua, Central America
Graham, William E.....1514A Stratosphere Lane, England AFB, Alexandria, La.
Hagman, Norman A.....32 Delafield Dr., Ft. Leonard Wood, Mo.
Hathaway, C. Bishop.....Irwin Army Hospital, Ft. Riley, Kans.
Hurt, LaVerne B.....3102 Palm Ave., Delray Beach, Fla.
Jones, Roland W.....3rd Marine Division, % FPO, San Francisco, Calif.
Kammen, Robert.....2136 Barclay Rd., Oklahoma City, Okla.
Kenoyer, Wilbur L.....7520th USAF Hospital, APO 125, New York, N. Y.
Kurtz, Richard.....4302-6 O'Donnell Hdqrs., Ft. Riley, Kans.
Lawler, George F...P. O. Box 923, Cape Coral, Fla.
Little, John W. (S).....Mt. Zion, Illinois
McCarthy, Daniel F., Jr.....2nd Battalion, 34th Infantry, APO 112, New York, N. Y.
McConnaughey, Hal D.....U. S. Naval Hospital, Great Lakes, Ill.
McLain, C. R., Jr...Wright-Patterson AFB, Ohio
Mertz, Henry O., Sr. (S).....R. R. 2, Box 1619, Nokomis, Fla.
Moore, Richard B.....931 St. Paul Ave., #9 St. Paul, Minn.
Morrow, Dean H...National Institutes of Health, Bethesda, Md.
Murray, James S.....2068 Ventura Blvd., Camarillo, Calif.
Musser, A. Wendell.....Laboratory Service, Durham, N. C.
Myers, Roy V. (S).....7710 Beta Circle, West Palm Beach, Fla.
Need, Richard L.....NINDB Research Center, Guam Memorial Hospital, Agana, Guam
Nelson, John W...Box 98, University of Tennessee, Memphis, Tenn.
Newman, Daniel M.....USAF, Vandenburg, Calif.
Ochsner, Harold C., Jr.....704 Garden Ave., Bellevue, Nebr.
Parks, Herbert E.....9407 Winsome Lane, Houston 42, Texas
Pearson, Lyman R.....1881 Ridgeway Dr., Clearwater, Fla.
Pebworth, Aubrey C. (S).....14115 S. Wabash, Chicago, Ill.
Pittman, John N.....University Hospital, Ann Arbor, Mich.
Rabb, Aaron....Veterans Hospital, Louisville, Ky.
Rapp, George F.....4313 Willingham Dr., Columbia, S. C.
Reibel, Donald B.....U. S. Naval Hospital, Beaufort, S. C.
Rhea, Kenneth E.....U.S.S. Holland, (AS-32) FPO, New York, N. Y.
Rhodes, Theodore D.....R. R. 2, Box 1595, Nokomis, Fla.
Ricketts, Joseph W. (S).....136 Magnolia Dr., Orman Beach, Fla.
Rigg, John F. (S).....1279 N. E. 97th St., Miami Shores, Fla.
Robinson, Frank C. (S).....200 Via Mentone, Newport Beach, Calif.
Rogers, Thomas P.....6142 LaPintura Dr., La Jolla, Calif.
Rudolph, Stephen J., Jr.....832nd TAC Hospital, Cannon AFB, New Mexico
Rust, Byron K.....PMC/USAID, American Embassy, APO 271, N. Y., N. Y.
Scheeringa, Ronald H.....1222 Meridene, Baltimore, Md.
Schumacher, Richard R.....8-22 Medical Group, Turner AFB, Albany, Ga.
Smith, Stephen M.....R. R. 4, Box 325-B, Montgomery, Ala.
Talarico, Leonard H.....219 Orland Rd., Rochester 22, N. Y.
Wilson, David O.....3650-A Morton Rd., Ft. McClellan, Ala.
Ziperman, H. Haskell.....Medical Division, Hdqrs. USAREUR, APO 403, New York, N. Y.

MARSHALL COUNTY

Hampton, James N.....Argos
Kelly, Frank (S).....Argos
Rea, Ralph L.....Argos
Connell, Vactor O.....Bourbon
Kemp, W. Alfred.....Bourbon
Marshall, George L. (S).....Bourbon

Bremen

Bowen, Otis R.....424 W. South St.
Burket, Cecil R.....424 W. South St.
Cripe, Earl P.....119 N. Center St.
Schreiner, John E.....201 E. Plymouth
Stine, Marshall E.....424 W. South St.

Culver

Baker, Milan D.....Culver Military Academy
Hippensteel, Russell R.....121 College Ave.
Howard, Joseph D.....112½ N. Main St.
Reed, Donald W.....121 Mill St.

Plymouth

Coursey, James O.....109 N. Walnut St.
France, Lloyd C.....1223 N. Center St.
Guild, John K.....1167 Pennsylvania
Kubley, James D.....304 N. Walnut St.
Peterson, Ronald L.....116 E. Washington St.
Reed, Robert G., Jr.....109 N. Walnut St.
Reno, Edward C.....700 Ferndale St.
Rimel, James F.....1223 N. Center St.
Robertson, James S.....304 N. Walnut St.
Vore, Louring W.....116 E. Washington St.

Thompson, Alfred A. (S).....Tyner

MARTIN COUNTY

(See Daviess-Martin)

MIAMI COUNTY

Shrock, Ethan E.....Amboy
Crates, Gordon C.....Denver
Sixbey, Maurice D.....Denver
Malott, Fred R.....Converse
Sennett, William K.....Macy
Rendel, Harold E.....Mexico

Peru

Carlson, Edward A. (S).....11½ W. Main St.
Ferrara, Donald W.....18 W. Fifth St.
Ferrara, Samuel J.....18 W. Fifth St.
Guthrie, James U.....331 W. Third St.
Herd, Cloyn R.....15 S. Wabash St.
Hill, Lloyd L.....65 N. Miami St.
Malouf, Stephen D. (S).....Box 431
Snyder, Parker W.....65 N. Miami St.

MONROE COUNTY

(See Owen-Monroe)

MONTGOMERY COUNTY

Crawfordsville

Alexander, Stephen J.....408 W. Market St.
Baird, Malcolm K.....411 Ben Hur Bldg.
Burks, Jess E.....411 Ben Hur Bldg.
Cornell, Robert A.....206 Ben Hur Bldg.
Daugherty, Fred N.....120 W. Pike St.
Dodds, Wemple.....Culver Hospital
Eggers, Richard.....120 W. Pike St.
Haller, Thomas C.....411 Tinsley Ave.
Humphreys, John W.....312 Jones St.
Kirtley, James M.....416 Ben Hur Bldg.
Lingeman, Byron N.....419 Ben Hur Bldg.
Ludwig, Paul E.....306 Ben Hur Bldg.
Millis, Samuel C.....416 Ben Hur Bldg.
Peacock, Norman F.....219 Ben Hur Bldg.
Pierson, Robert H.....305 E. Main St.
Shannon, Wesley E.....408 W. Market St.
Viray, Victoriano G.....411 Tinsley Ave.
Wallace, Hawthorne C.....R. R. Donnelley Co.

Otten, Ralph E.....Darlington
Priebe, Fred H. Marion Co. Gen. Hosp., Indianapolis
Blix, Fred M.....Ladoga
Kindell, Hurschell D.....New Richmond
Hales, Robert E.....Roachdale
Richards, Edgar E.....Russellville
Thompson, Claude N.....Waynetown
Parker, Carl B.....Wingate

MORGAN COUNTY

Martinsville

Brubeck, Robert E.....215 E. Washington St.
Drake, Ellery T.....P. O. Box 110
Eisenberg, David A.....Sunnyside Dr.
Gray, Leon.....171 E. Washington St.
Miller, Ray D.....290 E. Washington St.
Ostheimer, George.....215 E. Washington St.
Pitkin, McKendree C.....440 Washington St.
Reese, Jay S.....Sunnyside Dr., P. O. 30
Van Wienen, John.....60 W. Morgan
Willan, Horace R. (S).....109 S. Jefferson St.
Winter, William P.....1390 E. Columbus

Mooresville

Comer, Kenneth E.....130 Indiana St.
Kendrick, William M.....130 Indiana St.
Kourany, Edgar.....320 N. Indiana St.
Kourany, Oscar.....320 N. Indiana St.
Van Bokkelen, Robert W.....320 N. Indiana St.

Miller, Robert J.....Paragon

NEWTON COUNTY

Schoonveld, Arthur.....Brook
Parker, John C.....Goodland
Kresler, Leon E.....101 N. 4th St., Kentland
Yegerlehner, Roscoe S...103 N. 2nd St., Kentland
Guzman, Marcelino F...331 W. Beaver St., Morocco

NOBLE COUNTY

Bowman, Charles M.....Albion
Nash, Justin R.....Albion
Sneary, Max E.....Avilla

Kendallville

Bryan, Robert E.....705 N. State St.
Gutstein, Richard R. (S).....120 Diamond
Hepner, Herman.....705 N. State St.
Lawson, Isaac H. (S).....125½ S. Main St.
Messer, Frank W.....115 E. Rush St.
Slough, Richard R.....115 E. Williams St.
Stallman, Carl F.....409 E. Wayne St.

Ligonier

Hooker, Donald J.....406 S. Main St.
Stone, Robert C.....401 S. Main St.
Stultz, Quentin F.....401 S. Calvin St.

Slough, O. Thomas
4130 N. Kessler Blvd., Indianapolis (8)
Fipp, August L.....Rome City
Pulskamp, Bertrand H.....Wolcottville

OHIO COUNTY

(See Dearborn-Ohio)

ORANGE COUNTY

Hagan, Marion L.....French Lick Springs
Keseric, N. E.....French Lick Springs
Sugarman, Benjamin E.....French Lick Springs
Hodgin, Phillip T.....Orleans
Schoolfield, William E.....Orleans
Clark, Ivan A.....Paoli
Manship, C. Stanley.....Paoli
McCalla, Charles X.....Paoli
Spears, John K.....Paoli

OWEN-MONROE COUNTIES

Bloomington

Baxter, Neal E.....306 E. Fifth St.
Bidney, Evelyn B.....321 S. Jordan Ave.
Bomba, Brad J.....1920 E. Third St.
Booze, James H.....400 E. Third St.
Borland, Raymond M.....114 N. Lincoln St.
Buckingham, Richard E.....344 S. College Ave.
Byrne, Louis E.....311 E. Fifth St.
Cochran, John F.....Indiana University
Creek, Jean A.....1920 E. Third St.
Emery, Charles B., Jr.....400 E. Third St.
Farr, James C.....311 E. Kirkwood Ave.
Fowler, Richard R.....104 N. Grant
Geiger, Dillon D.....300 E. Kirkwood Ave.
Hardtke, Eldred F.....509 E. Fourth St.
Hepner, Herman S.....312 N. Walnut St.
Holland, Deward J. (S).....313 N. College Ave.
Holland, Philip T.....108 W. Seventh St.
Holtzman, Paul W.....615 N. College Ave.
Houshmand, Cyrus.....422 E. Kirkwood Ave.
Klein, Emanuel.....Indiana University
Link, William C.....110 E. Fourth St.
Lundblad, Wilfred M.....1805 E. Tenth St.
Lyons, Robert E.....321 E. Fifth St.
McClary, Charles W.....120 Kingston Pl.
McIntire, Clarence R.....Bloomington Hospital
Manifold, Harold M.....1920 E. Third St.
Marchant, Clarence H.....350 S. College Ave.
Middleton, Thomas O.....400 W. Second St.
Milan, Joseph F.....311 E. Kirkwood Ave.
Miller, John M.....Indiana University
Owen, Margaret T.....200 S. Washington St.
Pizzo, Anthony.....Bloomington Hospital
Poolitsan, George C.....407 N. Walnut St.
Ramsey, Hugh S.....307 E. Kirkwood Ave.
Rieger, I. Taylor.....102 N. Grant St.
Rogers, Otto F., Jr.....210 N. Washington St.
Rollins, Thomas K.....114 E. Seventh St.

Ross, Ben R.....314 E. Seventh St.
Ross, James B.....314 E. Seventh St.
Schell, H. Richard.....422 E. Fifth St.
Schultheis, Richard L.....916 Mitchell St.
Schuman, Edith B.....Indiana University
Sibbitt, Joseph W.....300 E. Fifth St.
Smith, Herschel S.....110 S. Lincoln
Smith, Rodney D. (S).....115 N. Washington St.
Spencer, Beaufort A.....114 N. Lincoln
Stangle, William J.....640 S. Rogers
Topolgus, James N.....403 N. Walnut St.
Way, James A.....322 E. Kirkwood Ave.
Wenzler, Paul J.....110 S. Washington St.
Wilson, Talmage L.....301 E. Kirkwood Ave.

Mitchell, George L. (S).....Smithville

Spencer

Brown, Marcel S.....53 W. Market St.
Kay, Oran E.....Main and Morgan Sts.
Roof, Roger S.....792 E. Morgan St.
Smith, Frederick R.....452 Lover's Lane

PARKE-VERMILLION COUNTIES

Goodrum, William R.....Cayuga

Clinton

Evans, Frederick J.....242 S. Third St.
Gailey, Ivan L.....231 Walnut St.
Herzberg, Milton.....222 Elm St.
Kercheval, John M.....819 S. Third St.

Somerville, J. W.....Fairview
Lauer, Dorothy B.....Dana
Webb, Lawrence C.....Dana
Britton, Welbon D.....Montezuma
Minich, William G.....FMC Corp., Newport

Rockville

Beebe, Milton O., Jr.....110 York St.
Bloomer, Richard S.....115 N. Market St.
Dowell, Emil H.....Ohio St.
Harstad, Casper.....216 W. High St.
Kempf, Gerald F.....Indiana State Hospital for Chest Diseases
May, William D.....Indiana State Hospital for Chest Diseases
Noblitt, James S. (S).....Rockville
Pirkle, Hubert B.....Indiana State Hospital for Chest Diseases

Fell, Robert M.....Rosedale
White, Chester S. (S).....Rosedale
Greene, Frederick G. (S).....Seelyville
Staff, Robert A...1239 S. Center St., Terre Haute
Pace, Jerome V.
210 Warman Ave., Indianapolis (22)

White, Isaac D. (S)
809 W. Broadway, Anaheim, Calif.

PERRY COUNTY

Bush, Hargis R.....Cannelton

Tell City

Dukes, David A.....521 Main St.
Gilbert, Robert G.....Perry Co. Mem. Hosp.
Herr, John W. (S).....622 Main St.
James, John M.....746 Ninth St.
James, Nicholas A. (S).....746 Ninth St.
Kemker, Bernard P.....746 Ninth St.
Lohoff, Lewis C.....507 Main St.
Neifert, Noel L.....507 Main St.
Ress, Gene E.....507 Main St.
Smith, Fred, Jr.....507 Main St.

PIKE COUNTY

Petersburg

Hall, Donald L.....7th & Poplar Sts.
Omstead, Milton.....110 S. Sixth St.

DeTar, George B. (S).....Moore Haven, Florida
Higgins, James L.
32nd USAF Hosp., Minot AFB, N. Dakota

PORTER COUNTY

Chesterton

Griffin, Joseph P.....Jackson Blvd.
Hall, Thomas C.....621 Broadway
Harless, Clarence M.....123 Indiana Ave.
Read, John E.....114 S. 11th St.
Robertson, William C.....600 E. Morgan

Portage

Carlson, Milton R.....14000 Central
Crise, John R.....14000 Central
Kilmer, Warren L.....14000 Central
Lands, Robert M.....14000 Central
Noonan, Leo C.....14000 Central
Tetrick, Lain.....National Steel Corporation

Valparaiso

Brown, James C.....1005 Campbell St.
Covey, Thomas J.....1 Sheffield Dr.
Davis, Carl M.....202 Indiana Ave.
DeGrazia, Eugene J.....810 LaPorte Ave.
Dittmer, Jack E.....60 Jefferson St.
Dittmer, Thomas L.....23 Lincolnway
Eades, Ralph C.....6 Napoleon St.
Frank, John R. (S).....23 Lincolnway
Gold, Marvin E.....1005 Campbell St.
Green, Leonard J.....1005 Campbell St.
Griffin, Charles G.....813 LaPorte Ave.
Koenig, Robert L.....810 LaPorte Ave.
Lee, Robert Y.....808 Lincolnway
Makovsky, Theodore.....1005 Campbell St.
O'Neill, Martin J.....810 LaPorte Ave.
Sacks, Leonard Z.....Porter Memorial Hosp.
Scheimann, Lois.....702 Lincolnway
Schmidt, Richard H.....Porter Memorial Hospital
Stoltz, Robert M.....501 Lincolnway
Vietzke, Paul C. F.....1005 Campbell St.
Wu, Stewart.....808 Lincolnway

Gordon, Joseph L.....Wheeler

POSEY COUNTY

Montgomery, Samuel B. (S).....Cynthiana
Woods, Arba L. (S)....25 S. E. Second St., #212, Evansville
Ropp, Harold E.....New Harmony
Boren, Paul R.....Poseyville

Mount Vernon

Challman, William B.....431 Walnut St.
Crist, John R.....105 E. Sixth St.
Hirsch, Herman L.....126 W. Fifth St.
Oliphant, Frank W.....701 Mulberry St.
Vogel, L. John.....131 W. Third St.

PULASKI COUNTY

Lacy, John D., Jr.....Medaryville
Eshelman, Henry R.....Monterey

Winamac

Carneal, Thomas E. (S).....111 N. Monticello
Halleck, Harold J.....119 W. Main St.
Hollenberg, Edward L.....210 S. Market St.
Thompson, William R.....111 N. Monticello

PUTNAM COUNTY

Veach, Lester W.....Bainbridge
Veach, Richard L.....Bainbridge
Gray, Clyde C. (S).....Cloverdale
Ellett, John, Jr.....Coatesville

Greencastle

Dettloff, Frederick R.....Alamo Bldg.
Johnson, James B.....105 E. Washington St.
Jones, Lawrence R.....250 Hillsdale Ave.
Nichols, Anne Sackett.....707 E. Seminary St.
Schauwecker, Cleon M.....239 Hillsdale Ave.
Smith, A. Wilson.....DePauw University
Steele, Dick J.....Alamo Bldg.
Stephens, James P.....Alamo Bldg.
Thompson, Edward C.....Vine Street
Tipton, William R.....110 S. Vine St.
Wiseman, V. Earle.....239 Hillsdale Ave.

RANDOLPH COUNTY

Nixon, Byron.....Farmland
White, Harvey E.....Farmland
Jordan, Leo E.....Lynn
Martin, Charles E. (S).....Lynn
Shallenberger, Henry R.....Modoc
Potter, Richard M.....Ridgeville

Union City

Birum, Patricia J.....333 W. Oak St.
Chambers, Carol R.....Chambers Medical Clinic
Chambers, Leroy B.....Chambers Medical Clinic
McClure, Morris E.....333 W. Oak St.
Phipps, Leland K.....227 W. Oak St.
Reid, Robert W. (S).....726 W. Division St.
Wagoner, B. D.....Columbia and Lennox St.

Winchester

Dininger, William S.....303 S. Main St.
Engle, Russell B.....210 S. Main St.
Koch, Howard W.....208 E. Washington St.
Painter, Lowell W.....124 E. Franklin St.
Slick, Crystal R.....457 Elm St.
Sparks, Paul W.....214 S. Main St.

Sullivan, Daniel R.....2467 Woodville Rd., Oregon, Ohio
Ruby, Fred McK. (S)
1222 N. Cass St., Milwaukee, Wisc.

RIPLEY COUNTY

Freeland, Bill E.....12 E. Boehringer, Batesville
Hisrich, Lloyd W...222 Maplewood Ave., Batesville
Paras, Jose L.....Batesville
Warn, William J.....Milan
Row, George S.....Osgood
Smith, R. Lee.....Osgood
McConnell, William C.....Sunman
Parker, John B. Versailles

RUSH COUNTY

McNabb, George B. (S).....Carthage
McNabb, Richard C.....Carthage
Smith, Stephen D.....Knightstown
Sheets, Charles E.....Manilla
Worth, C. Willard.....Milroy

Rushville

Atkins, Clarence C.....225 N. Morgan St.
Corpe, Kenneth F.....R. R. #4
Dean, Donald I.....Fourth & Main
Ellis, Davis W.....E. 11th St.
Green, Frank H.....134 E. Second St.
Lee, John M. (S).....914 N. Morgan St.
McKee, Harry G.....208 W. First St.
Norris, Marvin G.....134 E. Second St.
Nutter, Wyndham H.....1003 N. Morgan
Schneider, Marvin C.....E. 11th St.

ST. JOSEPH COUNTY

Zeitler, Philip S.....1400 Hudson St., Elkhart
Hartsough, Ralph I.....Lakeville
Smith, Lee, Jr.....21620 Leeper Rd., Lakeville

Mishawaka

Barone, Carmelo V.....307 W. Fourth St.
Christophel, Verna A.....109 W. Third St.
Farner, James E.....114 Lincoln Way W.
Ganser, Richard A.....111 S. Race St.
Gerig, Eldon L.....123 W. Fourth St.
Goethals, Charles J.....602 Lincoln Way W.
Macri, Paul A.....116½ W. Third St.
Mahank, Camiel C.....223 S. Spring St.
Malstaff, Comiel M.....113 S. Church St.
Orr, W. Robert.....114 Lincoln Way W.
Reed, Robert F.....1316 Lincoln Way E.
Rosenwasser, Jacob.....225 Lincoln Way E.
Schaphorst, Richard A.....113 S. Church St.
Sirlin, Edward M.....109 S. Church St.
Spalding, Wendell L.....427 Lincoln Way E.
Stringer, Drennon D.....303 S. Main St.
Templeton, Ames R.....522 Calhoun St.
Van Rie, Leo Paul (S).....116 S. West St.
Walerko, Frank M.....122 S. Race St.
Walters, Charles E.....319 S. Spring St.
Whitlock, Francis C.....110 N. Race St.
Whitlock, Merle E.....123 W. Fourth St.
Wurster, Herbert C.....221 E. Third St.,
Zimmer, Henry J.....119½ Lincoln Way W.

Luzadder, John E.
105 W. Michigan St., New Carlisle
Calvin, Helen M.....P.O. Box 38, North Liberty
Calvin, O. Walter.....P.O. Box 38, North Liberty
Hardy, John J. (S)...P.O. Box 23, North Liberty
Warrick, Homer L....106 Lincolnway W., Osceola
Helmen, Harry W. (S).....Rolling Prairie

South Bend

(Zip Code 466 plus zone number.)

A

Acker, Robert B. (S).....418 Sherland Bldg. (1)
Arisman, Ralph K.....607 Odd Fellows Bldg. (1)

B

Backs, Alton J.....1401 Lincoln Way (28)
Baran, Charles.....402 Sherland Bldg. (1)
Bartsch, Harvey L.
919 E. Jefferson Blvd., #102 (17)

Beach, Norman F.....919 E. Jefferson Blvd., #107 (17)
Bebensee, Donald L.....122 N. Lafayette (1)
Bechtold, S. E...919 E. Jefferson Blvd., #302 (17)
Bell, Horace D.....420 N. Hill St. (17)
Bell, Robert L.....531 N. Main St. (1)
Bennett, Jene R.....531 N. Main St. (1)
Berke, Robert D.....1118 Lincoln Way E. (18)
Biasini, Benedict A.....403 Dixie Way, N. (17)
Bickel, David A. (S)..515 Odd Fellows Bldg. (1)
Birmingham, Peter J. (S).426 Sherland Bldg. (1)
Bixler, Louis C. 919 E. Jefferson Blvd., #207 (17)
Bodnar, Leslie M.....525 N. Michigan (1)
Bogan, William C.....1512 Hass (15)
Booth, Franklin M.....430 Sherland Bldg. (1)
Borough, Lester D.....710 J. M. S. Bldg. (1)
Brechtl, Harvey J.
919 E. Jefferson Blvd., #104 (17)
Buchanan, Wallace D.
919 E. Jefferson Blvd., #107 (17)
Buechner, Frederick W.
116 N. Main St., #261 (1)
Buslee, Roger M.....531 N. Main St. (1)
Bussard, Clifford F. (S)
202 Whitcomb-Keller Bldg. (1)
Bussard, Frank W.
202 Whitcomb-Keller Bldg. (1)
Butts, Milton A.....118 N. Walnut St. (28)

C

Carter, F. R. Nicholas (S)
2000 E. Jefferson Blvd. (17)
Cassady, James V.....815 Sherland Bldg. (1)
Cassady, John R.....815 Sherland Bldg. (1)
Chamblee, Roland W.
336 N. Notre Dame Ave. (17)
Clark, William H.....520 Sherland Bldg. (1)
Colip, George D.....514 Sherland Bldg. (1)
Colosey, Frederick J...3121 Mishawaka Ave. (15)
Cook, Gordon C.....719 N. Main St. (1)
Cooper, Harry L. (S)....410 Sherland Bldg. (1)
Culbertson, Carl S.....531 N. Main St. (1)
Custer, Edward W.....Healthwin Hosp. (17)

D

Davis, Edward A.....3014 Ardmore Trail (28)
Denham, Robert H..... 919 E. Jefferson Blvd., #204 (17)
DeVoe, Kenneth Roy....418 N. Michigan St. (1)
Dietl, Ernest L.....820 Sherland Bldg. (1)
Dingley, Albert F.
919 E. Jefferson Blvd., #204 (17)
Dodd, Robert.....2311 N. Miami St. (14)
Dolezal, Bernard J.....115 S. Eddy St. (17)
Donnelly, Everett.....527 N. Michigan St. (1)
Dunlap, D. Logan.....203 J.M.S. Bldg. (1)

E

Eades, R. Charles....914 E. Jefferson Blvd. (17)
Edwards, Bernard E.....704 N. Main St. (1)
Egan, Sherman.....203 J.M.S. Bldg (1)
Engel, Howard R.
919 E. Jefferson Blvd., #403 (17)
English, John Paul....120 N. Lafayette Blvd. (1)
Ericksen, Lester G.
919 E. Jefferson Blvd., #207 (17)
Erickson, Gustaf W...120 N. Lafayette Blvd. (1)

F

Feferman, Martin E.
919 E. Jefferson Blvd., #305 (17)
Feldman, Max.....1921 Miami St. (14)
Filipek, Walter J.....311 Odd Fellow Bldg. (1)
Firestein, Ben Z. 919 E. Jefferson Blvd., #307 (17)
Firestein, Ray.....416 Sherland Bldg. (1)
Fish, Edson C.....326 Sherland Bldg. (1)
Fisher, Lawrence F. (S)....1717 E. Colfax (17)
Foley, Hansel O.
919 E. Jefferson Blvd., #408 (17)
Forrest, O. Norman, Jr.....719 N. Main St. (1)
Frank, Herbert.919 E. Jefferson Blvd., #202 (17)
Frank, Lyall L., Jr.....224 W. Navarre St. (1)
Frank, Lyall L.....224 W. Navarre St. (1)
Frash, DeVon W.....1910 Miami St. (14)
Frash, DeVon W., Jr.....1910 Miami St. (14)
Frey, William B.....316 N. Ironwood Dr. (15)
Friedman, Morris S.
919 E. Jefferson Blvd., #402 (17)
Frith, Louis G.....521 W. Washington Ave. (1)

G

Gaffney, Raymond.....535 W. Colfax Ave. (1)
Ganser, Ralph V.....302 Sherland Bldg. (1)
Gates, George E.....122 N. Lafayette Blvd. (1)
Gilman, Marcus M.....401 Odd Fellow Bldg. (1)
Godersky, George E.
919 E. Jefferson Blvd., #106 (17)
Graf, John Paul.....326 Sherland Bldg. (1)
Green, G. Richard.....822 Sherland Bldg. (1)
Green, George F.....822 Sherland Bldg. (1)
Green, Norval E.....704 N. Main St. (1)
Grillo, Donald.....226 Sherland Bldg. (1)
Grorud, Alton C.....120 N. Lafayette Blvd. (1)
Grove, James H. 919 E. Jefferson Blvd., #107 (17)

H

Haley, George M.....424 Sherland Bldg. (1)
Haley, Paul E.....816 Sherland Bldg. (1)
Hall, James M.....914 E. Jefferson Blvd. (17)
Hamilton, Charles O.....527 N. Michigan St. (1)
Hanley, Harriet Faith
919 E. Jefferson Blvd., #101 (17)
Haugseth, Ellsworth K.
122 N. Lafayette Blvd. (1)
Hawkins, Glen E.....527 N. Michigan St. (1)
Helmer, John F.....826 Sherland Bldg. (1)
Hilbert, John W. (S)
410 W. Washington Ave. (1)
Hildebrand, John O., Jr..1307 E. Ewing Ave. (14)
Hill, Theodore A.....107 N. Eddy St. (17)
Hill, Wallace C.
919 E. Jefferson Blvd., #306 (17)
Holdeman, Lillian S.....228 S. St. Joseph St. (1)
Holdeman, Richard W..404 N. Lafayette Blvd. (1)
Holtzman, Norman N...3123 S. Michigan St. (14)
Houser, D. Stanley.....2314 Miami (14)
How, Louis E.....513 W. Indiana Ave. (14)
Hyde, Carroll C. (S)..120 N. Lafayette Blvd. (1)

J-K

Jankowski, Ernest B...411 S. Sheridan Ave. (19)
Johns, Nicholas C.....116 E. Jefferson (1)
Kamm, Bernard A.....526 Sherland Bldg. (1)
Karn, John W.....326 Sherland Bldg. (1)
Knapp, Arthur L. (S).2215 Mishawaka Ave. (15)
Knode, Kenneth T.....729 Sherland Bldg. (1)
Krueger, John E.....326 Sherland Bldg. (1)
Kuhn, Frederick L.....1215 S. Michigan St. (18)

L

Lamb, J. Leonard
919 E. Jefferson Blvd., #401 (17)
Lane, William H.....418 N. Michigan St. (1)
Lester, Vern L..919 E. Jefferson Blvd., #107 (17)
Levatin, Bernard I.
919 E. Jefferson Blvd., #303 (17)
Levkoff, Abner H.....919 E. Jefferson Blvd., #101-03 (17)

Lionberger, John R.
919 E. Jefferson Blvd., #207 (17)
Liss, Emanuel C.....119 S. Eddy St. (17)
Lockhart, Philip B.
919 E. Jefferson Blvd., #107 (17)

M

MacDonell, Eldred H...122 N. Lafayette Blvd. (1)
McCraley, William J.....218 S. Francis (17)
McDonald, Ralph M.....502 J.M.S. Bldg. (1)
McFarland, Corley B...122 N. Lafayette Blvd. (1)
McMeel, James.....1138 Whitehall Dr. (15)
Marquis, Gordon.....120 N. Lafayette Blvd. (1)
Martinov, William E.
919 E. Jefferson Blvd., #301 (17)
Mason, Bernard A.....120 N. Lafayette Blvd. (1)
Mauzy, Merritt C.....919 E. Jefferson Blvd. (17)
Metcalfe, Grant E.
919 E. Jefferson Blvd., #308 (17)
Miller, Milo K. (S)..122 N. Lafayette Blvd. (1)
Mott, Cassell A...1301½ W. Washington St. (16)
Mueller, Hilbert M....120 N. Lafayette Blvd. (1)
Murphy, Eugene C....122 N. Lafayette Blvd. (1)
Murphy, Josephine F.....111 W. Bartlett St. (1)
Myers, Philip R.....1002 Lincoln Way W. (16)

N-O

Neher, John L.....17615 State Rd. #23
Nelson, F. Dale.....704 N. Main St. (1)
Nelson, Raymond E.....206 E. Bartlett St. (1)
Olson, Donald T. 919 E. Jefferson Blvd., #309 (17)
Olson, Kenneth L.....919 E. Jefferson Blvd., #207 (17)
Oren, William F.....919 E. Jefferson Blvd. (17)

P

Pairitz, Frank D.....60649 U. S. 31 S. (14)
Parsons, Robert.....919 E. Jefferson Blvd. (17)
Pascuzzi, Chris A.....531 N. Main St. (1)
Pauszek, Thomas B...704 W. Washington St. (6)
Petrass, Andrew (S).....516 Sherland Bldg. (1)
Phelps, Stephen R.....818 Sherland Bldg. (1)
Plain, George.....122 N. Lafayette Blvd. (1)
Proudfit, Charles H.
919 E. Jefferson Blvd., #304 (17)
Pyle, Harold D.....119 S. Eddy St. (17)

R

Rasmussen, Ruth F...122 N. Lafayette Blvd. (1)
Rigley, Edward L.....408 Sherland Bldg. (1)
Roberts, Billy J.....3123 Mishawaka Ave. (15)
Rodin, Herman H.....822 Oakridge (17)
Rosenheimer, George M...418 N. Michigan St. (1)
Rubens, Eli.....2314 Miami (14)
Rudolph, Carl J.....110 W. Bartlett St. (1)

S

Sanderson, Robert B.....730 Sherland Bldg. (1)
Sandock, Louis F.....503 Sherland Bldg. (1)
Sandoz, Harry H.....612 Odd Fellow Bldg. (1)
Schiller, Herbert A.
919 E. Jefferson Blvd., #205 (17)
Scott, Frank M.....122 N. Lafayette Blvd. (1)
Selby, Keith E.....407 Lincoln Way W. (1)
Sellers, Francis M.....3209 Mishawaka Ave. (15)
Sharp, Merle C.....717 N. Main St. (1)
Shelley, Edward S.....207 S. Taylor St. (25)
Shriber, William H...122 N. Lafayette Blvd. (1)
Shriner, Richard Lee
919 E. Jefferson Blvd., #308 (17)
Sisson, Norvel D.....531 N. Main St. (1)
Skillern, Penn G. (S).....1014 E. Fox St. (14)
Skillern, Scott D.....422 Sherland Bldg. (1)
Slominski, Harry H. (S)
708 Odd Fellows Bldg.(1)
Spenner, Raymond W.....726 Sherland Bldg. (1)
Staunton, Henry A.....3016 Mishawaka Ave. (15)
Stiver, Daniel D.....822 Sherland Bldg. (1)
Stogdill, William J.....525 Sherland Bldg. (1)
Stratigos, Joseph S.....527 N. Lafayette Blvd. (1)

T

Thompson, John M.....305 Sherland Bldg. (1)
Thompson, Robert A.
913 S. Twyckenham Dr. (15)
Thornton, Maurice J.
919 E. Jefferson Blvd., #107 (17)
Tirman, Wallace S.
919 E. Jefferson Blvd., #207 (17)
Traver, Perry C. (S)....1010 Riverside Dr. (16)

U-V-W-X-Y-Z

Urruti, Arnoldo H.....420 J.M.S. Bldg. (1)
Vagner, S. Bernard....2201 Lincoln Way W. (8)
VanFleit, William E.
919 E. Jefferson Blvd., #407 (17)
Vurpillat, Francis J...132 N. Lafayette Blvd. (1)
Wack, James E.....530 W. Indiana Ave. (14)
Walker, Edwin M., Jr.....326 Sherland Bldg. (1)
Ward, James W.....325 Wakewa (17)
Weiss, Eugene.....919 E. Jefferson Blvd. (17)
White, Donald G.....1815 Ireland Rd. (14)
Wilhelm, Agatha M..1032 E. Wayne at Eddy (17)
Wilson, James M.....919 E. Jefferson Blvd. (17)
Wixted, John F...919 E. Jefferson Blvd., #1 (17)
Wixted, Julia L...919 E. Jefferson Blvd., #1 (17)
Zeiger, Irvin L.....3123 Mishawaka Ave. (15)

Blackburn, Erwin
Beatty Memorial Hosp., Westville
Hillman, Marion W.....Box 473, Westville
Cline, Kenneth L.....Box 57, Wyatt

Bassler, Carl R. (S).....R. R. # 4, Niles, Mich.
Fish, Clyde M. (S)
R. R. # 2, Edwardsburg, Mich.
Martin, Charles F., Jr.....611-67th Ave., N.E., Minneapolis, Minn.

SCOTT COUNTY

Bogardus, Carl R.....61 Main St., Austin

Castro, Ignacio B.....Wanda St., Scottsburg
McClain Marvin L.....935 First St., Scottsburg
Sabens, James A.....69 Wardell St., Scottsburg

SHELBY COUNTY

Nigh, Rufus M.....Fairland
Davis, John A.....Flat Rock

Shelbyville

Arata, Lucian A..... 327 W. Broadway
Dalton, Wilson L.....117 W. Washington St.
Green, William L.....103 W Washington St.
Inlow, Herbert H.....103 W. Washington St.
Inlow, Paul M.....103 W Washington St.
Inlow, Robert P.....103 W. Washington St.
Inlow, William D. (S)....103 W. Washington St.
Miller, Richard C.....17 Mechanic St.
Moheban, Joseph.....120 W. Jackson St.
Paz, Luis.....526 E. McKay Rd.
Richard, Norman F.....103 W. Washington St.

Scott, V. Brown.....103 W. Washington St.
Silbert, David B.....17 S. Tompkins
Spindler Robert D.....165 W. Mechanic St.
Tindall, William R.....505 S. Harrison St.
Tower, James H., Jr.....124 W. Franklin St.
Whitcomb, Roger F.....120 W. Jackson St.

SPENCER COUNTY

Medcalf, Norman L.....Lamar
Jolly, Wesley P. (S).....Richland
Glackman, John C., Jr.
6th and Main Sts., Rockport
Monar, Michael.....6th and Main Sts., Rockport

STARKE COUNTY

Leinbach, Earl R.....Hamlet

Knox

DeNaut, James F.....4 N. Heaton St.
Henry, Howard J.....107 S. Main St.
Ingwell, Guy B.....201 S. Heaton St.
McClure, Clark.....107 S. Main St.

Llamas, Dominador F. 520 Lane St., North Judson

STEUBEN COUNTY

Angola

Artz, Richard W.....416 E. Maumee
Barton, Robert.....625 S. Superior St.
Cameron, Don F.....416 E. Maumee
Cameron Mary H.....416 E. Maumee
Crum, Marion M.....301 E. Maumee
Davis, Claude E.....909 W. Maumee
Hartman, John J.....209 W. Felicity
Kissinger, Knight L.....Elmhurst Hospital
Mason, Donald G.....416 E. Maumee
Rausch, Norman W.....416 E. Maumee

Blosser, Blaine A. (S).....Fremont
McCormack, Lloyd L.....Fremont
Schrepferman, Wayne.....Hamilton

SULLIVAN COUNTY

Brown, John S.....Carlisle
Whipps, Charles E. (S).....Carlisle
Dukes, Betty.....Dugger
Dukes, Frederic M. (S).....Dugger
Dukes, Joe E.....Dugger
Bethea, Robert O.....Farmersburg
Hernandez, Antonio.....Shelburn

Sullivan

Bedwell, Marion H.....16 N. Court St.
Crowder, James H.....112 N. Section St.
Eskew, Kenneth W.....117 W. Washington St.
McClure, Glen.....342 S. Main St.
Maple, James B. (S).....117 W. Washington St.
Scott, Irvin H.....117 W. Washington St.

Daugherty, William L.....Hutsonville, Ill.
Taylor, John R.....105 N. Main, Palestine, Ill.

SWITZERLAND COUNTY

(See Jefferson-Switzerland)

TIPPECANOE COUNTY

Derhammer George L.....Brookston
Gish, Howard M.....Brookston
Dublin, Madeline P.....Francesville

Lafayette

Ade, Charles H.....2211 South St.
Ade, Mary Keller.....2211 South St.
Baker, John R.....405 Life Bldg.
Balkema, Catherine M.....3 N. 18th St.
Bayley, William E.....2400 South St.
Beuerman, V. A. 2600 Greenbush St.
Bolin, Robert C.....2600 Greenbush St.
Bridge, Barton C.....Jefferson Square
Buhrmester, Harry C.....2600 Greenbush St.
Burns, John T.....5 N. 25th St.
Bush, Jack A.....405 Life Bldg.
Calvert, Raymond R.....314 N. Sixth St.
Canganelli, Vincent G.....2433 S. Ninth St.
Carpenter, James B.....15 N. 25th St.
Cole, Ira.....2315 South St.
Coyner, Alfred B. (S).....509 Life Bldg.
Davis, Grayson B.....2211 South St.
Davis, Howard B.....2600 Greenbush St.
Deur, Julius J.....1011 Columbia
Donahue, George R.....718 Life Bldg.
Dubois, Ramon B.....23 N. 25th St.
Eaton, Marion J.....214 Life Bldg.
Elliott, Paul W.....35 N. 25th St.
Engeler, James E.....2600 Greenbush St.
Ferguson, William B.....2525 South St.
Fields, Donald C.....2600 Greenbush St.
Flack, Russell A.....1005 Life Bldg.
Fox, Richard F.....2600 Greenbush St.
Frasch, Mahlon G.....300 Life Bldg.
Frey, Harley H., Jr.....405 Life Bldg.
Gery, Richard E.....2600 Greenbush St.
Gripe, Richard P.....2600 Greenbush St.
Haas, Charles F.....2211 South St.
Hannemann, Robert E.....2600 Greenbush St.
Harden, Murray E.....903 Life Bldg.
Harter, Eli B.....2600 Greenbush St.
Harvey, Bennett B.....35 N. 25th St.
Heid, George J., Jr.....35 N. 25th St.
Herrold, George W.....2 N. 26th St.
Holladay, Lloyd J.....411 Life Bldg.
Horswell, Richard R.....2600 Greenbush St.
Hughes, Richard R.....31 N. 25th St.
Hull, James E.....2211 South St.
Hunsberger, Walter G.....2600 Greenbush St.
Hunter, Frank P. (S).....617 Life Bldg.
Johnson, Herbert S.....2600 Greenbush St.
Johnson, Lowell R.....2522 South St.
Jones, David M.....24 N. 24th St.
Karberg, Richard J.....2420 Ferry St.
Klatch, Ben Z.....2211 South St.
Klepinger, Harry E.....824 Life Bldg.
Kohne, Robert W.....3010 Underwood
Kuipers, Fred M.....2600 Greenbush St.
Landis, Charles B.....2211 South St.
Loop, Frederick A.....914 Life Bldg.
McAdams, Hugh B.....2011 Kossuth St.
McAdams, Robert.....2011 Kossuth St.
McClelland, Donald C. (S)..1021 Highland Ave.
McFadden, James M.....35 N. 25th St.
McKinley, Joseph.....312 Life Bldg.
McKinney, Daniel H.....301 Life Bldg.
McPherson, Richard C.....2600 Greenbush St.
Marsh, George W.....1216 Howell
Martin, Joe M.....2316 South St.
Marvel, Howard R.....2600 Greenbush St.
Mather, Charles R.....2600 Greenbush St.
Mather, Robert L.....609 Life Bldg.
Miller, Albert J.....35 N. 25th St.
Miller, Roland E.....2200 Scott St.
Mount, William M.....20 N. 24th St.

Neumann, Kenneth O.....618 Life Bldg.
Onorato, Joseph J.....2433 S. Ninth St.
Peyton, Frank W.....2424 Ferry St.
Ratcliff, Frank W.....405 Life Bldg.
Ricchetti, Warren F.....1120 N. 15th St.
Riggs, Wendell A.....2600 Greenbush St.
Rothrock, Philip W.....2200 Scott St.
Ruschli, Edward B. (S).....510 Life Bldg.
Russell, Henry T.....St. Elizabeth Hospital
Shively, John L.....2525 South St.
Sholty, William M.....405 Life Bldg.
Smith, Lowell C.....637 Ferry St.
Stahl, Edward T.....2600 Greenbush St.
Steele, Hugh H.....2600 Greenbush St.
Strayer, Joseph W.....612 Life Bldg.
Stuntz, Edgar C.....Wabash Valley Hospital
Trout, Carl J.....314 N. Sixth St.
Tubbs, George R. (S).....2502 Iroquois Trail
Underwood, George M.....Jefferson Square
Van Buskirk, Edmund L.....2600 Greenbush St.
Van Den Bosch, Wallace R.....2216 South St.
Vermilya, Robert W.....405 Life Bldg.
Wagner, Anabel.....405 Life Bldg.
Wagner, Lindley.....Jefferson Square
Waits, Chester L.....15 N. 25th St.
Webster, Paul L.....2600 Greenbush St.
Weller, Wendell A.....2600 Greenbush St.

Wong, Norman F.....Linden
Peterson, Joel A.....R. R. 5, Monticello
Babb, Forrest J.....Stockwell

West Lafayette

Ash, Harold H.....712 Bexley Rd.
Carroll, Bertha Rose.....Purdue University
Crockett, Franklin S. (H).....424 Littleton St.
Meikle, Louise J. (S).....606 Terry Lane
Rommel, Clarence H.....456 Northwestern
Schmiedicke, Paul H.....Purdue University
Spurlock, Fae H.....Purdue University
Van Kirk, John R.....724 Northwestern Ave.
Wilms, John H.....Purdue University

TIPTON COUNTY

Haller, Robert L.....Kempton
Stouder, Albert E.....Kempton
Tranter, William F.....Sharpsville

Tipton

Burkhardt, Boyd A.....202 S. West St.
Carter, Jean V.....130 N. Main St.
Compton, George L.....219 N. Independence
Gossard, Meredith B.....308 N. Independence
Kincaid, Raymond K.....202 S. West St.
Kurtz, William A.....202 S. West St.

Ericson, Harold L.....Windfall
Moser, Elmer B. (S).....Windfall

UNION COUNTY

(See Wayne-Union)

VANDERBURGH COUNTY

(Zip Code 477 plus zone number.)

Evansville

A

Acre, Robert R.....706 Walnut St. (8)
Adler, Raymond N.....714 Second Ave. (10)
Adye, Wallace M.....1307 N. Stringtown Rd. (11)
Alexander, John E.....7720 Lauderdale Dr. (15)
Anderson, Milton H...Evansville State Hosp. (2)
Antes, Earl H.....420 Cherry St. (13)
Arendell, Robert E.....1400 Cass Ave. (14)
Austin, Eugene W.....3700 Bellemeade (15)

B

Baker, Herman M. (S).....715 First Ave. (10)
Barnhart, Willard T.....701 Chestnut St. (13)
Bebout, Donald E.....Mead Johnson & Co., 2404 Pennsylvania St. (21)
Beck, Robert E.....600 Mary St. (10)
Begley, Joseph W., Jr. 314 S. E. Riverside Dr. (13)
Beisel, Larry H.....420 Cherry St. (13)
Bender, Martin J.....912 Hulman Bldg. (8)
Bennett, Abner P.....412 S. E. Fourth St. (13)
Bissonnette, Roger P.....420 Cherry St. (13)
Bloss, Bryant A.....715 First Ave.
Boone, Robert D.....420 Cherry St. (13)
Boswell, Robert W. C.....2351 Division St. (14)
Boyd, Stella N.....502 Hulman Bldg. (8)
Brakel, Frank J., Jr.....420 Cherry St. (13)
Britt, Robert L.....420 Cherry St. (13)
Brockmole, Arnold W...201 S. E. Third St. (13)
Brown, George W.....Mead Johnson & Co., 2404 Pennsylvania St. (21)
Bryan, Stanton L.....607 Hulman Bldg. (8)
Buddrus, David J.....Edward Dalton Co., 2010 W. Ohio St. (12)
Buehner, Donald F.....3700 Bellemeade (15)
Burger, Thomas C.....3700 Bellemeade (15)
Burnikel, Ray H.....527 Sycamore St. (8)
Burress, Clyde R.....723 Mary St. (10)

C

Cacia, John J.....402 S. E. Seventh St. (10)
Carlson, Ralph F.....517 Sycamore St. (8)
Clark, Thomas W.....420 Cherry St. (13)
Clouse, Paul A.....613 S. Weinbach Ave. (14)
Cockrum, William M.....908 Hulman Bldg. (8)
Coleman, Joseph E.....3700 Bellemeade (15)
Combs, Herman T.....807 W. Indiana (10)
Combs, John H.....412 S. E. Fourth St. (13)
Cooper, Waller W.....Deaconess Hospital (10)
Corcoran, Patrick J. V.....3700 Bellemeade (15)
Crawford, James H.....221 Chestnut St. (13)
Crevello, Albert J.....3700 Bellemeade (15)
Crimm, Paul D.....Boehne Hospital (12)
Crudden, Charles H...Clearview Sanitarium (10)
Cullnane, Chris W.....2312 W. Franklin St. (12)

D

Daves, W. Lawrence.....715 First Ave. (10)
Davidson, Harold H.....420 Cherry St. (13)
Davis, Max D.....Mead Johnson & Co., 2404 Pennsylvania St. (21)
Deems, Myers B.....314 S. E. Riverside Dr. (13)
Denzer, Edward K.....108 S. E. Third St. (8)
Denzer, William O.....923 Bellemeade (13)
Dieckman, Herbert S.....3700 Bellemeade (15)
Dodd, Roberts K.....2042 Lincoln Ave. (14)
Downer, Luther H.....521 Oak Street (13)
Drake, Dale W.....St. Mary's Hospital (10)
Durkee, Melvin S.....3700 Bellemeade (15)
Durkin, John W., Jr.....Mead Johnson & Co., 2404 Pennsylvania St. (21)
Dycus, Walter A.....319 N. St. Joseph Ave. (12)
Dyer, Wallace K.....3700 Bellemeade (15)

E

Ebin, Judah L.....101 S. E. Third St.
Eisterhold, John A...5300 New Harmony Rd. (12)

Engel, Edgar L.....126 S. E. Seventh St. (8)
Ewer, Robert W.....420 Cherry St. (13)

F

Faith, Ira L.....805 Old Nat'l. Bank Bldg. (8)
Faul, Henry J.....815 Hulman Bldg. (8)
Faw, Melvin L.....420 Cherry St. (13)
Fenneman, Robert J.....402 S. E. Seventh St. (8)
Fickas, Dallas.....715 First Ave. (10)
Fisher, William C.....715 First Ave. (10)

G

Garland, Edgar A.....606 S. Weinbach (14)
Garst, Garland R.....3700 Bellemeade (15)
Gaul, L. Edward.....509 Hulman Bldg. (8)
Geller, Samuel.....R. R. 8, Box 143A
Getty, William H.....420 Cherry St. (13)
Giorgio, Douglas J.....916 S. Burkhardt Rd. (15)
Gourieux, E. De Verre.....3700 Bellemeade (15)
Greenburg, Louis T.....2301 W. Michigan St. (12)
Griep, Arthur H.....5414 Madison Ave. (15)
Grimm, William C. H.....420 Cherry St. (13)
Guckien, Joseph L.....715 First Ave. (10)

H

Hammond, R. Case.....701 Chestnut St. (13)
Hare, Daniel M.....7800 Taylor (15)
Harlan, William L.....3700 Bellemeade (15)
Harned, Ben K.....420 Cherry St. (13)
Harris, Robert L.....4 Woodmere Lane (15)
Hart, L. Paul.....3700 Bellemeade (15)
Hartley, Clarence A., Jr...221 Chestnut St. (13)
Hartz, F. Minton.....123 S.E. Second St. (8)
Hassel, Walter B.....1905 E. Division St. (14)
Heard, Albert.....322 E. Cherry St. (13)
Heinrich, Weston A...314 S. E. Riverside Dr. (13)
Hendershot, Eugene L...412 S. E. Fourth St. (13)
Hermayer, Stephen....220 S. E. Seventh St. (13)
Herrmann, Gordon T.....3700 Bellemeade (15)
Herzer, Clarence C.....322 N. Fulton (10)
Himebaugh, Gilbert J.....115 N. Weinbach (11)
Hobbs, Arthur A.....600 Mary St. (10)
Hobgood, James L., Jr. 3700 Washington Ave. (15)
Hoopes, Jane M.....3700 Bellemeade (15)
Hoover, J. Guy.....517 Sycamore St. (8)
Hovda, Richard B.....St. Mary's Hospital (15)
Huggins, Victor S.....715 First St. (10)
Hyatt, Gilbert T.....1106 W. Franklin St. (10)

J

Johnson, Harold V.....2301 W. Michigan St. (12)
Johnson, Stephen L.....521 Sycamore St. (8)

K

Kauffman, Harley M.....219 Walnut St. (8)
Kelly, John B.....420 Cherry St. (13)
Kessler, Robert B.....1338 Division St. (14)
Kiechle, Frederich L.....726 S. E. First St. (13)
Kimmel, George E.....214 Indiana Bank Bldg. (8)
Kincaid, Robert S.....1000 N. Spring St. (11)
Kleindorfer, Roscoe L...819 W. Franklin St. (10)

L

Laubscher, Clarence.....1201 Laubscher Rd. (10)
Lawrence, Joseph C.....715 N. First Ave. (10)
Leibundguth, Henry.....3700 Bellemeade (15)
Leich, Charles F.....124 S. E. First St. (8)
Lessure, Alfred P.....420 Cherry St. (13)
Lewis, Earl T.....Mead Johnson & Co.,
2404 Pennsylvania St. (21)
Lynch, Harold D.....Mead Johnson & Co.,
2404 Pennsylvania St. (21)

M

MacKenzie, Pierce.....126 S. E. Seventh St. (8)
McCool, Joseph H.....1 Woodmere Lane (15)
McDonald, Joseph D.....517 Sycamore St. (8)
McPherson, Thomas C.....Mead Johnson & Co.,
2404 Pennsylvania St. (21)
Manner, Richard J.....Mead Johnson & Co.,
2404 Pennsylvania St. (21)
Marvel, James A.....420 Cherry St. (13)
Mason, Everett E.....118 S. E. First St. (8)
Mathews, James R.....715 First Ave. (10)
Maxson, Roy V.....401 Mary St. (10)
Miller, LaVerne B.....714 N. Main St. (11)
Miller, Milton J.....15 W. Franklin St. (10)
Mills, Fred E.....Deaconess Hospital (10)
Mino, Robert A.....723 Mary St. (10)
Moulton, Lillian G.....1 N. Barker (12)
Muelchi, Adeline F.....518 Hulman Bldg. (8)
Murphy, Edward U.....901 Hulman Bldg. (8)

N

Nenneker, Henry (S)..1912 Harmony Way (12)
Newnum, Raymond L.....3700 Bellemeade (15)
Newsome, Cola K.....415 E. Mulberry (13)
Nicholson, Raymond W.....3700 Bellemeade (15)
Niedermayer, Alfred J. 960 Washington Ave. (13)
Nonte, Leo R.....715 First Ave. (10)
Noveroske, Richard J.....Deaconess Hospital (10)

O

Oswald, Robert H.....126 S. E. Seventh St. (8)

P

Pastor, Julius W.....3700 Washington Ave. (15)
Pavlick, Theodore J.....908 Hulman Bldg. (8)
Pemberton, Jack J.....319 N. St. Joseph Ave. (12)
Porro, Francis W.....3700 Washington Ave. (15)
Present, Julian.....3700 Bellemeade (15)
Price, Shirley G.....420 Cherry St. (13)
Pugh, Willis L.....715 First Ave. (10)

R

Radcliff, Forest F.....3700 Bellemeade
Ratcliffe, Albert W.....P. O. Box 624
Reich, Clarence E.....1209 N. Fulton (10)
Rietman, H. Jerome
19 Chandler, off Riverside (13)
Ritchie, William D.....555 Herndon Dr. (11)
Ritz, Albert S.....3700 Bellemeade (15)
Robinson, Earle U.....615 Bellemeade (13)
Rosato, Edward J.....19 Chandler Ave. (13)
Rosenblatt, Bernard B.....709 Hulman Bldg. (8)
Royster, George M. (S)
401 Citizens Nat'l. Bank Bldg. (8)
Royster, Robert A.
401 Citizens Nat'l. Bank Bldg. (8)
Rudolph, Kenneth J.....3700 Bellemeade (15)
Rupper, Warren R...R. R. 3, Box 159, Heckel Rd.
Rusche, Henry J.....313 W. Iowa (10)
Russell, Richard H...3700 Washington Ave. (15)

S

Schimmelpfennig, Robert W.
1013 Parrett St. (13)
Schirmer, Robert H.....1118 W. Franklin St. (12)
Schneider, Charles P...2211 W. Franklin St. (12)
Schriefer, Victor V.....1120 N. Main St. (11)
Sheehan, E. Gregg.....420 Cherry St. (13)
Shively, Wyant J.....3700 Washington Ave. (15)
Sinn, Charles M.....715 First Ave. (10)
Slaughter, Howard C.....908 Hulman Bldg. (8)
Slaughter, John C., Jr.....3700 Bellemeade (15)
Slaughter, Owen L.....3700 Bellemeade (15)

Smith, Gordon L.....19 Chandler Ave. (13)
Smith, Roy M.....1307 Stringtown Rd. (11)
Snively, William D., Jr.....Mead Johnson & Co., 2404 Pennsylvania St. (21)
Sprecher, Herman C.....527 Sycamore St. (8)
Springstun, Walter R.....715 First Ave. (10)
Stallings, Hugh A.....3700 Bellemeade (15)
Steele, Paul W.....1218B Lincoln Ave. (14)
Sterne, John H.....3700 Bellemeade (15)
Stewart, L. Ray.....852 S. Alvord Blvd. (14)
Stork, Urban F. D.....420 Cherry St. (13)
Strueh, Paul E.....220 S. E. Seventh St. (13)

T

Tager, Stephen N.....3700 Bellemeade (15)
Thompson, Naiad Mason....420 Cherry St. (13)
Tilden, Margaret H.....700 Mary St. (10)
Tisserand, John B., Jr.....3700 Bellemeade (15)
Tuholski, James M.....Mead Johnson & Co., 2404 Pennsylvania St. (21)
Turner, Isabel B...Evansville State Hospital (2)
Tweedall, Daniel C.....715 First Ave. (10)

U-V

Venables, Albert J.....600 Mary St.
Viehe, Robert W. (S)....618 S. Willow Rd. (14)
Visher, John W. (S)
805 Old National Bank Bldg. (10)
VonderHaar, Thomas E.....715 First Ave. (10)

W

Walter, Paul A. F., III.....Mead Johnson & Co., 2404 Pennsylvania St. (21)
Walter, Robert F.....1514 S. Kentucky Ave. (14)
Warner, Charles L.....420 Cherry St. (13)
Waters, George E...Evansville State Hospital (2)
Weber, Edgar H.....123 S. E. Second St. (8)
Weiss, Henry G. (S)....1014 E. Powell Ave. (14)
Welborn, Mell B.....420 Cherry St. (13)
Westerman, Richard L.....Mead Johnson & Co., 2404 Pennsylvania St. (21)
Wilhelmus, C. Kenneth..115 S. E. Seventh St. (8)
Wilhelmus, Gilbert M..1028 Washington Ave. (16)
Willis, Charles F.....1100 S. Bedford Ave. (13)
Willison, George W.....3700 Bellemeade (15)
Wilson, David.....1709 Southeast Blvd. (14)
Wilson, John D.....3700 Bellemeade (15)
Wilson, Ralph.....517 Mary St. (10)
Woods, William P. (S)....5050 Lincoln Ave. (15)
Woodson, Dan E.....28 E. Powell Ave. (13)
Woodward, Ben E.....420 Cherry St. (13)
Wynn, Justice F.....905 Hulman Bldg. (8)

X-Y-Z

Young, C. Curtis.....126 S. E. Seventh St. (8)
Zeier, Francis G.....420 Cherry St. (13)
Zimmerman, Harold.....6 S. E. Second St. (8)
Ziss, Robert C.....216 S. E. Riverside (13)
Zwickel, Ralph E.....906 Hulman Bldg. (8)

Baylor, Joseph P.
123-4 Sirrocco Dr., Minot AFB, N. Dakota
Cymbala, Bohdan.....Methodist Hospital, Adkinson Park, Henderson, Ky.
Ehrich, William S. (S)....Manning, So. Carolina
Lyman, Frank L.....Geigy Chemical Corp., P. O. Box 430, Yonkers, N. Y.
Mayberry, Alton R.
Shady Lawn Rd., Chapel Hill, N. C.
Newman, Alvin E.
2937 Coral Shores Dr., Ft. Lauderdale, Fla.

VERMILLION COUNTY

(See Parke-Vermillion)

VIGO COUNTY

Loving, Jury B.....New Goshen
McIntosh, Wilbert.....Riley
Jett, Clyde W.....Seelyville

Terre Haute

A

Allen, Orris T. (S).....320 Robinwood Dr.
Allen, William H.....423 Rose Dispensary Bldg.
Anderson, Walter C.....2235 Wabash Ave.
Ault, Roy J.....3050 Poplar St.

B

Bannon, William G.....416 Rose Dispensary Bldg.
Blum, Leon L.....1505 N. Seventh St.
Bopp, Henry W., Jr.....221 S. Sixth St.
Bopp, James.....Union Hospital
Boyd, H. Clark.....221 S. Sixth St.
Bradley, Stephen C. (S).....916 S. 25th St.
Bristol, Henry M. S.....1218½ Wabash St.
Bronson, Paul J.....3050 Poplar St.
Brown, Robert R.....221 S. Sixth St.
Burkle, Robert J.....3050 Poplar St.

C

CaJacob, Melville E.....1000 S. Sixth St.
Caldwell, Milton V.....721 Wabash Ave.
Cavins, Alexander W.....221 S. Sixth St.
Chau, Andrew Y. S.....1030 S. Sixth St.
Combs, Stuart R.....3050 Poplar St.
Conforti, Victor P.....221 S. Sixth St.
Congleton, George C. (S)
308 Merchants National Bank Bldg.
Conklin, James O.....310 Rose Dispensary Bldg.
Connerley, Marion L.....107 S. Seventh St.
Conway, Thomas J.....221 S. Sixth St.
Crockett, Wayne A.....500 Rose Dispensary Bldg.

D

Davis, Paul E.....1233 Maple Ave.
Dierdorf, Fred W.....Union Hospital
Drummy, William W.....221 S. Sixth St.
Dyer, George W.....2235 Wabash Ave.

E

Edwards, Henry G.....6 Rose Dispensary Bldg.

F

Freed, John E., Jr.....1030 S. Sixth St.

G

Gerrish, Donald A.....5206 Clinton Road
Gillotte, Joseph P.....1505 N. Seventh St.
Goodman, Hubert T...410 Rose Dispensary Bldg.
Gossom, Donn R.....203 Rose Dispensary Bldg.

H

Harkness, Robert G...301 Rose Dispensary Bldg.
Haslem, Ezra R.....401 Rose Dispensary Bldg.
Haslem, John R.....221 S. Sixth St.
Hogan, Thomas W.....627 Cherry St.
Hoover, Dewey A.....1218½ Wabash Ave.
Humphrey, Paul E.....1235 Ohio Blvd.
Hunt, Edgar J.....R. R. 1
Johnson, Edward M.....221 S. Sixth St.
Johnson, Paul D., Jr.....822 N. 15th St.
Justin, Renate G.....901 S. 25th St.

K

Kabel, Robert N.....3050 Poplar St.
Krieble, William W.....221 S. Sixth St.
Kunkler, Arnold W.....1700 N. Seventh St.
Kunkler, Joseph (S).....14 S. Fifth St.
Kunkler, William C. (S)
212 Merchants Nat'l. Bank Bldg.

L

LaBier, Clarence R. (S).....325 Ohio St.
LaBier, Clarence R., Jr.....325 Ohio St.
Lancet, Robert O.....2101 Wabash Ave.
Lee, James.....St. Anthony Hospital
Loewenstein, Werner L.....1537 S. Seventh St.
Luckett, Coen L. (S).....211 Fairbanks Bldg.
Lyons, L. Mason.....59 S. 18th St.

M

McAleese, George B.....1030 S. Sixth St.
McBride, Noel S..407 Merchants Nat'l. Bank Bldg.
McCrea, Fred R.....221 S. Sixth St.
McEwen, James W.....670 Cherry St.
McLaughlin, Gordon C.....3227 Wabash Ave.
Mahoney, Charles L.....221 S. Sixth St.
Malone, Leander A.....416 Tribune Bldg.
Mankin, William J.....402 Tribune Bldg.
Mason, Lester M...312 Merchant Nat'l. Bank Bldg.
Mattox, Don M.....1700 N. Seventh St.
Meissel, Robert L.....920 N. 19th St.
Meyn, Werner P.....221 S. Sixth St.
Miklozek, John E.....1461 S. Seventh St.
Milleson, Ann L. M.....826 S. Center St.
Mitchell, John R.....221 S. Sixth St.
Musselman, Glen G.....1021 S. Sixth St.

N-O

Nay, Ernest O. (S).....221 S. Sixth St.
Neudorff, Louis G.....221 S. Sixth St.

P

Pearce, Roy V.....1440 S. 25th St.
Pu, Pin H.....1021 S. Sixth St.

R

Reed, Robert C.....Union Hospital
Reynolds, Richard J.....2250 Wabash Ave.
Richart, James V.....414 Rose Dispensary Bldg.
Riggs, Floyd C.....2216 Wabash Ave.
Rogers, R. Shirrell.....26 N. Sixth St.,
West Terre Haute
Rourke, Robert F.....1724 N. Seventh St.
Rubin, Milton M.....221 S. 19th St.

S

Sayers, Frank E. (S).....436 Bluebird Dr.
Scherb, Burton E.....104 N. Seventh St.
Schott, Edward J. (S).....653 Oak St.
Schumaker, Robert A.....3050 Poplar St.
Scully, William E.....221 S. Sixth St.
Shanklin, Vernon A. (S).....672½ Wabash Ave.
Showalter, John R.....1233 Maple Ave.
Siebenmorgen, Paul.....1200 S. Eighth St.
Silverman, Norman M.....1634 S. Seventh St.
Speas, Robert C.....402 Tribune Bldg.
Stewart, Walter E. (S).....402 Tribune Bldg.
Stoelting, J. Lewis.....1724 N. Seventh St.
Strecker, William L.....2006 Wabash Ave.
Strong, Daniel S. (S).....2618 Lafayette Ave.
Sullivan, John M.....1712 Franklin St.

T-U-V

Topping, Malachi C.....3050 Poplar St.
Veach, William L.....1235 Ohio St.
Voges, Edward C.....702 College Ave.

W

Walden, Heinz J.....1616 N. Ninth St.
Weber, Joseph G. S.....723 Wabash Ave.
Weinbaum, Jack G.....206 Rose Dispensary Bldg.
Wheeler, Byron C.....3050 Poplar St.
White, James V.....721 Wabash Ave.
Wilson, Fred L.....1501 S. Third St.
Wohlfeld, Gerald M.....1807 S. 10th St.

X-Y-Z

Zwerner, Paul F.....12 Points State Bank Bldg.

Denny, E. Rankin.....413 Madison Ave., #2,
Cape Kennedy, Florida

WABASH COUNTY

Poehler, Fred C.....La Fontaine
Walker, James L. (S).....La Fontaine

North Manchester

Balsbaugh, George K.....10 7W. Seventh St.
Bunker, Ladoska Z.....201 N. Mill St.
Cook, Charles E.....114 W. Main St.
Eiler, Paul A.....1104 N. Wayne St.
Seward, George W.....111 E. Main St.
Smith, Lloyd H.....1104 N. Wayne St.

Dunham, Henry H.....Roann

Wabash

Boaz, William D.....645 N. Spring St.
Dannacher, William D.....400 Ash St.
Dragoo, John R.....Washington & Ash St.
Elward, Carl J.....R. R. #4
Hanneken, Vincent J.....Washington & Ash St.
LaSalle, Richard M.....645 N. Spring St.
LaSalle, Robert M., Jr.....645 N. Spring St.
LaSalle, Robert M., Sr.....645 N. Spring St.
Mills, John F.....24 E. Main St.
Pearson, William E.....290 N. Wabash
Rauh, Robert A.....884 N Miami St.
Steffen, Julius T.....443 N. Wabash
Stoops, Jean T.....280 N. Wabash
Whisler, Frederick M. (S).....10 W. Hill
Zydlo, Stanley M.....Wabash Professional Bldg.

Kidd, James G. (S).....720 West Racine St.,
Apt. B, Jefferson, Wis.

WARREN COUNTY

(See Fountain-Warren)

WARRICK COUNTY

Boonville

Dimmett, James D.....214 S. Second St.
Hoover, Peter B.....223 W. Locust St.
Stover, Wendell C.....125½ S. Second St.
Terry, Robert H.....117 S. Second St.
Wilson, Paul E. (S).....126 N. Third St.

Colvin, Robert C.....Newburgh
Wilhelmus, Charles M. (S).....Newburgh

WASHINGTON COUNTY

Tower, Thomas K.....Campellsburg
Carty, Charles B.....Pekin

Salem

Apple, Eddie R.....501 W. Market St.
Coleman, Henry G.....Mitchell Bldg.
Episcopo, Arsenius R.....401 W. Mulberry St.
Fultz, Roy L.....304 E. Market St.
Huckleberry, Irvin E.....502 W. Mulberry St.

WAYNE-UNION COUNTIES

Hill, Paul G.....Cambridge City
Kenyon, Charles E.....Cambridge City
Barton, Willoughby M.....Centerville
Hutchison, Donald R.....Fountain City

Liberty

Clarkson, Clarence G.....304 E. Union St.
Lewis, James F.....28 E. Union St.
McWilliams, William B.....207 N. Market St.

Richmond

Adney, Frank B.....1015 S. A St.
Ake, Loren.....213 Medical Arts Bldg.
Allen, Robert T.....34 S. Seventh St.
Anderson, Robert C.....Richmond State Hosp.
Ballenger, William E.....309 Medical Arts Bldg.
Blossom, Paul W.....825 S. A St.
Brooks, G. Tanner.....29 S. 12th St.
Brown, Richard J.....84 S. 14th St.
Buche, Frederick P. (S).....106 S. Seventh St.
Coble, Frank H.....51 S. Eighth St.
Cox, Leon T.....1210 E. Main St.
Daggy, James R.....35 S. Eighth St.
Dingle, Paul E.....216 Medical Arts Bldg.
Dreyer, Ralph W.....2 S. W. 17th St.
Ebbinghouse, Tom.....98 W. Main St.
Gibson, Alois E.....1250 Chester Blvd.
Guthrie, James R.....1010 S. A St.
Hagie, Franklin E.....1110 S. A St.
Hance, Darwood B.....Reid Memorial Hospital
Harmon, Carl J.....407 Medical Arts Bldg.
Hill, Gladys Marie.....407 Medical Arts Bldg.
Hunt, Gayle J.....425 S. 19th St.
Johnson, George M.....1250 Chester Blvd.
Kendall, William R.....126 S. 24th St.
Kime, Charles E.....1201 S. A St.
Klepfer, Jefferson F....Richmond State Hospital
Kreitl, Dorothy R.....Richmond State Hospital
Lee, Glen Ward.....139 Medical Arts Bldg.
Ling, John F.....1250 Chester Blvd.
Logan, James Z.....84 S. 14th St.
Loomis, Charles H.....1203 S. A St.
McIlroy, Richard J.....1912 E. Main St.
Mader, John H.....2000 E. Main St.
Malcolm, Russell L.....127 Medical Arts Bldg.
Meredith, Elwood J.....203 Medical Arts Bldg.
Miller, Harold L. 1250 Chester Blvd.
Millis, Arthur B.....1250 Chester Blvd.
Morgan, Peter P.....808 S. A St.
Park, Byron J.....1250 Chester Blvd.
Pentecost, Paul S.....1300 Chester Blvd.
Plasterer, Edward D.....212 S. 16th St.
Porter, George S.....808 S. A St.
Ramsdell, Glen A.....1015 S. A Street
Ross, Harry P.....220 S. 19th St.
Runge, Paul W.....1426 E. Main St.
Sage, Charles V., Jr.....48 S. 11th St.
Schmitt, Robert W.....25 Circle Drive
Sherer, Kenneth E.....1250 Chester Blvd.
Shields, Tom S.....47 S. 11th St.
Smith, John R.....617 S. A St.
Snyder, Morris C.....130 Medical Arts Bldg.
Stepleton, John D.....Reid Memorial Hospital
Stilwell, William R.....2607 South C Place
Sweet, Howard E.....35 E. Eighth St.
Wanninger, Horace ..408 Second Nat'l. Bank Bldg.
Warrick, Francis B.....1426 E. Main St.
Weinstein, Edwin B.....204 Colonial Bldg.
Weitemier, Raymond A.....2000 E. Main St.
Wertenberger, Morris D...Reid Memorial Hospital
Wiland, Olin K.....Reid Memorial Hospital
Wilson, Edward A. 308 Medical Arts Bldg.
Wynegar, David E.....Richmond State Hospital
Zore, Joseph J.....1308 North A Street

Shepard, Fred F.....College Corner, Ohio
Hiatt, Russell L.....1203 Eastgate Dr., Venice, Florida

WELLS COUNTY

Bluffton

Boonstra, Charles E.....303 S. Main St.
Bradley, Louis F.....303 S. Main St.
Buckner, Joy F.....116 E. Walnut St.
Caylor, Charles H.....303 S. Main St.
Caylor, Harold D.....303 S. Main St.
Caylor, Truman E.....303 S. Main St.
Collins, Jack T.....303 S. Main St.
Cook, Robert G.....303 S. Main St.
Dorrance, Thomas O.....303 S. Main St.
Eisaman, Jack L.....303 S. Main St.
Gitlin, Max M.....121 E. Market St.
Gitlin, William A.....121 E. Market St.
Hamilton, Orville G. (S).....227 S. Main St.
Huffman, Galen C.....303 S. Main St.
Jackson, Charles E.....303 S. Main St.
Kephart, S. Bruce.....303 S. Main St.
Lehman, Emery W.....904 S. Bennett St.
Matzen, Richard N.....303 S. Main St.
Mayock, Peter P.....303 S. Main St.
Mead, Clarence H. (S).....227 S. Main St.
Meier, Donald W.....303 S. Main St.
Milroy, Robert A.....303 S. Main St.
Panos, Constantine G.....227 S. Main St.
Phillips, John F.....303 S. Main St.
Pietz, David G.....303 S. Main St.
Rusher, Merrill W.....303 S. Main St.
Sorg, David A.....303 S. Main St.
Steckbeck, Robert L.....303 S. Main St.
Stevens, Adam C.....303 S. Main St.
Strehler, Don A.....303 S. Main St.
Symon, William E.....303 S. Main St.
Talbert, Pierre C.....303 S. Main St.
Yoder, Richard P.....303 S. Main St.

Gingerick, Charles M.....Liberty Center
Hardin, Wayne E.....Ossian

Rutledge, Carl E., Jr.....Grandview Dr., Bowling Green, Ky.
Rudy, Donald B.
P. B. 636, Salisbury, Southern Rhodesia

WHITE COUNTY

Galbreth, Jesse P. (S).....Burnettsville
Houser, Wayne W.....Monon
McClure, Stanley E.....Monon

Monticello

Beck, David C.....135 S. Illinois St.
Dickerson, W. Martin.....1114 O'Connor Blvd.

Fullerton, Robert L.....201 Beach Dr.
Hibner, Nolan A.....110 S. Main St.
Jehanyar, M. Ali.....116 N. Illinois St.
Morris, Warren V.....115 Court St.

Mayfield, Clifford H. (S).....Reynolds
Baynes, Frank L.....Wolcott
Forbes, Violet Crabbe.....Wolcott

WHITLEY COUNTY

Hershey, Ernest A. (S).....Churubusco
Minick, Linus J.....Churubusco

Columbia City

Hamilton, Thomas.....115 S. Main St.
Heritier, C. Jules.....116 S. Chauncey
Langohr, John L.....215 E. Van Buren St.
Lehmberg, Otto F. C.....118 E. Van Buren St.
Niccum, Warren L.....215 E. Van Buren St.
Nolt, Ernest V. (S).....103 N. Line
Reid, Donald B.....118 E. Van Buren St.
Roth, James R.....323 N. Chauncey
Thompson, Frank M.....510 N. Main St.
Vogel, John L.....215 E. Van Buren St.
Wait, Jerome H.....115 S. Main St.
Wilson, John.....122 N. Main St.

Stalter, Gaylord W.....North Webster
Mishler, Joe B.....P. O. Box 276, Pierceton
Yoder, Dewey D.....R. R. #1, Pierceton
Huffman, Verlin P...701 State St., South Whitley

WOMAN'S AUXILIARY
to the
INDIANA STATE MEDICAL ASSOCIATION

OFFICERS: 1964-65

PRESIDENT	Mrs. Jack E. Shields	721 W. Spring St.	Brownstown
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FOURTH VICE-PRESIDENT	Mrs. R. J. Morrical	415 Highland St.	Logansport
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CORRESPONDING SECRETARY	Mrs. Wm. D. Scharbrough		Brownstown
FINANCE SECRETARY	Mrs. Charles O. Weddle	1210 N. East St.	Lebanon
HISTORIAN	Mrs. Edward L. Rigley	1704 Ridgedale Rd.	South Bend
PARLIAMENTARIAN	Mrs. Frank Gastineau	4444 Kessler Blvd., E. Dr.	Indianapolis

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AMA-ERF (TREASURER)	Mrs. Philip Ball	2820 W. Main St.	Muncie
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INTERNATIONAL HEALTH ACTIVITIES	Mrs. W. Burleigh Matthew	800 W. Kessler Blvd.	Indianapolis
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ORGANIZATION	Mrs. H. Carter Dunstone	2525 Paulding Rd.	Fort Wayne
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PUBLICITY	Mrs. Glen W. Irwin	8025 N. Illinois St.	Indianapolis
RURAL HEALTH	Mrs. Francis H. Gootee	R. R. #1	Jasper
SAFETY	Mrs. E. Robert Jacobs	1629 Franklin St.	Columbus
LIAISON OFFICER to the Indiana Chapter of W.A.S.A.M.A.	Mrs. John G. Suelzer	4041 Melbourne Rd.	Indianapolis
1964 ISMA CONVENTION CHAIRMAN	Mrs. Herbert L. Egbert	419 West 63rd St.	Indianapolis
1965 CONVENTION CHAIRMAN, HOUSE OF DELEGATES	Mrs. Herbert L. Sedam	2819 Millersville Rd.	Indianapolis

MEMBERSHIP ROSTER—BY COUNTIES

ADAMS COUNTY

Berne

Beaver, Mrs. Norman E.....866 Columbia Dr.
Boze, Mrs. Robert L.....255 Dearborn St.
Burk, Mrs. James M.....Berne
Luginbill, Mrs. Howard.....817 W. Main St.

Decatur

Carroll, Mrs. John C.....R. R. 5
Doan, Mrs. John.....522 Jefferson
Freeby, Mrs. C. William.....R. R. 1
Girod, Mrs. Arthur H.....R. R. 6
Parrish, Mrs. Richard K.....242 S. 2nd St.
Rich, Mrs. Norval S.....R. R. 4
Zwick, Mrs. Harold F.....104 E. Rugg

ALLEN COUNTY

Bluffton

Brickley, Mrs. Harry D.....227 S. Main St.
Buckner, Mrs. Winifred.....116 E. Walnut
Hamilton, Mrs. O. G.....203 E. Central Dr.
Mead, Mrs. C. H.....211 W. Washington

Fort Wayne

A

Adams, Mrs. E. Wade....1902 Forest Park Blvd.
Adams, Mrs. John R.....2538 Fairfield Vw. Pl.
Ahlbrand, Mrs. Roland C.....1242 Northlawn
Aiken, Mrs. Arthur F.....8331 Waterswolde Lane
Aiken, Mrs. Nevin E.....5540 Leo Rd.
Anderson, Mrs. Ernest.....2718 Schoper Drive
Andrew, Mrs. Jerald.....304 Maple Grove Ave.

Arata, Mrs. James.....126 Timber Lane
Arata, Mrs. Justin E.....224 Ludwig Rd.
Ashman, Mrs. William C.....7624 Wohama Dr.
Aust, Mrs. Charles H.....7137 Roseann Parkway

B

Ball, Mrs. John R.....4112 S. Harrison
Baltes, Mrs. Joseph H.....1309 Sunset Dr.
Barch, Mrs. John W.....4921 Desoto Drive
Bash, Mrs. Wallace E.....1201 Korte Lane
Beams, Mrs. Ralph.....3710 Wawonaissa
Beierlein, Mrs. Karl M.....2716 Butler Road
Bergendahl, Mrs. Emil.....1202 Illsley
Berghoff, Mrs. J. R.....3736 Plymouth
Berghoff, Mrs. Raymond.....4124 Cadena
Beutler, Mrs. Theodore....3505 S. Washington Rd.
Billingsley, Mrs. John.....4720 Crestwood
Blichert, Mrs. Peter A.....449 W. Sherwood
Bolman, Mrs. R. Morton.....5405 S. Wayne
Borders, Mrs. Theodore R.....1802 Nevada St.
Bossard, Mrs. John W.....1611 Alabama
Brandt, Mrs. William.....3535 Kirkland
Braunlin, Mrs. Robert J.....3420 Kirkwood Dr.
Bridges, Mrs. W. Lloyd.....207 Southridge Rd.
Bromley, Mrs. Luman W...410 W. Sherwood Ter.
Brosius, Mrs. Robert H.....3302 Garland
Brown, Mrs. Frederic W.....1813 Woodmoor
Brucker, Mrs. Perry A.....2933 Kingsley
Brueggeman, Mrs. Henry O...1202 W. Washington
Bryan, Mrs. Franklin A.....3006 Devon Dr.
Buckner, Mrs. Doster.....Bass Rd., R. R. 5
Buckner, Mrs. George D.....4327 Hampshire Dr.
Burkhart, Mrs. Charles A.....7621 Pinedale Dr.

C

Carlo, Mrs. Ernest.....5205 Indiana
Cartwright, Mrs. E. L.....3718 Hiawatha Blvd.
Chambers, Mrs. Alan.....4135 S. Harrison
Chase, Mrs. James A.....4120 N. Washington Rd.
Clark, Mrs. Wm. R.....4002 S. Harrison
Cochran, Mrs. Harry A., Jr..420 W. Sherwood Ter.
Connelly, Mrs. Richard.....3016 Kingsley Dr.
Cooney, Mrs. Charles J..2620 Covington Club Court
Cottrell, Mrs. Robert F.....5125 Worthman Ct.
Craig, Mrs. Richard.....5435 Woodhurst Blvd.
Culp, Mrs. John E.....2505 Paulding Rd.

D

Dahling, Mrs. Fred W.....1229 Rose Ave.
Datzman, Mrs. Richard.....5402 Bluffton Rd.
Dunstone, Mrs. H. Carter....2525 Paulding Road

E

Eberly, Mrs. Karl C.....1240 W. Rudisill
Emenhiser, Mrs. John L.....1407 Pinehurst Dr.
Engleman, Mrs. Reinhold.....3629 Chancellor Dr.

F

Farquhar, Mrs. John S.....2503 Drexel
Ferguson, Mrs. Arthur N.....328 W. Sherwood
Flaherty, Mrs. Robert....1835 Forest Park Blvd.
Frankhouser, Mrs. Chas. M...7245 Winchester Rd.
Fullam, Mrs. Richard.....4159 Woodstock

G

Garton, Mrs. Harry W.....R. R. 6, Hamilton Rd.
Gastineau, Mrs. David C.....8203 Westridge Rd.
Gentile, Mrs. J. Paul.....6821 Woodcrest Dr.
Gerding, Mrs. William J...1721 Forest Park Blvd.
Giffin, Mrs. Charles.....3222 Chancellor
Glassley, Mrs. Stephen.....6950 Stellhorn Rd.
Glock, Mrs. Wayne R.....Tonkel Road R.R. 2
Goebel, Mrs. Carl W.....4102 S. Harrison
Graham, Mrs. George M.....1126 W. Rudisill
Graham, Mrs. James C.....1825 Luther St.
Green, Mrs. Robert F.....4429 Hamilton Rd.
Greenlee, Mrs. Robert L.....3344 Sanibel Dr.
Griest, Mrs. Walter D.....4809 Arlington
Griffith, Mrs. Harold R...1913 Forest Park Blvd.

H

Hackett, Mrs. Walter G.....5220 Crandon Lane
Haffner, Mrs. Herman G.....3606 Mulberry Rd.
Haley, Mrs. Alvin J.....3720 Stellhorn Rd.
Hall, Mrs. William R.....4521 Highwood
Haller, Mrs. Richard C.....2525 Otsego
Hamilton, Mrs. Emory D.....2405 Florida Dr.
Hamilton, Mrs. George....2725 N. Anthony Blvd.
Hasewinkle, Mrs. August M...3544 Kirkland Lane
Hastings, Mrs. Warren C.....1822 Kensington Rd.
Hattendorf, Mrs. A. Paul.....4041 Old Mill Rd.
Havens, Mrs. Russell E.....3721 Inwood
Hershberger, Mrs. Philip G...5525 Covington Rd.
Hickman, Mrs. Donald M.....1815 Kensington Rd.
Hillery, Mrs. Robert.....3513 Kirkland Lane
Hipskind, Mrs. Richard E.....1416 Woodmoor
Hoffman, Mrs. Arthur F.....3619 Harris Rd.
Holsinger, Mrs. Robert E.....4617 Indiana
Hoover, Mrs. Joseph.....722 W. Creighton
Howe, Mrs. Fordyce L.....2540 Springfield
Humphreys, Mrs. John L...3701 S. Washington Rd.

I & J

Irmscher, Mrs. Geo. W.....2024 Florida Dr.
Isenogle, Mrs. Kenneth.....6016 Allendale Ct.
Jackson, Mrs. John F.....4922 Indiana
Johnston, Mrs. R. M.....2533 Bellevue Dr.
Jontz, Mrs. Joseph.....514 Shady Hurst Dr.
Jontz, Mrs. Richard L.....3705 Marigold Dr.
Juergens, Mrs. Richard.....6825 Ludwig Circle

K

Karol, Mrs. Herbert J.....1725 Ardmore
Kaufman, Mrs. Julian R.....1922 Hazelwood
Keck, Mrs. Carleton A.....4633 Crestwood
Kent, Mrs. Richard N.....2717 East Dr.
Keyes, Mrs. Robert C.....1226 Illsley
Kidder, Mrs. Orva T.....Lima Rd.
Kilgore, Mrs. Byron.....2804 Trent Dr.
Kimbrough, Mrs. Robert.....4601 Beaver Ave.
Kleifgen, Mrs. Wm. A.....4602 Tacoma
Kleopfer, Mrs. Ronald G.....3411 Eastwood Dr.
Klooze, Mrs. Kenneth W.....723 W. Packard
Knight, Mrs. Lewis W.....3502 Glencairn Dr.
Krueger, Mrs. John.....4418 Bradwood Terrace
Kruse, Mrs. Walter E.....4006 Spanish Trail

L

Ladig, Mrs. Donald S.....2720 Fairfield
Laker, Mrs. Gene.....4921 Tacoma
Laker, Mrs. Richard.....4750 Holton
Lampe, Mrs. Elfred H.....1018 Kinnaird
Land, Mrs. Francis L.....4129 S. Harrison Blvd.
Laycock, Mrs. Richard.....5019 Stellhorn Rd.
Leming, Mrs. Ben L.....314 W. Concord Lane
Lenk, Mrs. George G.....5507 E. State St.
Lloyd, Mrs. Robert P.....4111 Victoria Dr.
Logan, Mrs. Richard S.....3629 Hastings Rd.
Lohman, Mrs. Robert M.....1320 Westover Rd.
Lorman, Mrs. James G.....4926 Midlothian
Loudermilk, Mrs. Jack L.....3032 Glencairn Dr.
Loudermilk, Mrs. Richard.....2130 Hobson Road
Lyon, Mrs. William C.....4918 Northcrest Dr.

M

McArdle, Mrs. Edward G...1133 W. Rudisill Blvd.
McBride, Mrs. W. O.....610 Beechwood Circle
McCallister, Mrs. John W.....4215 Drury Lane
McCoy, Mrs. Roy R.....4101 S. Harrison
McDowell, Mrs. George A...2322 Forest Park Blvd.
McEachern, Mrs. Cecil.....4242 Old Mill Rd.
McKeeman, Mrs. Donald H.....1615 Ardmore
Mann, Mrs. R. E.....4035 Cadena Lane
Manning, Mrs. George.....4115 Indiana Ave.
Marshall, Mrs. Caesar L.....1215 McCulloch
Mastrangelo, Mrs. Michael J...2718 Priscilla Lane
Mensch, Mrs. James R.....2120 Forest Park Blvd.
Mercer, Mrs. S. R.....3235 N. Washington Rd.

Meyer, Mrs. Theo. O.....3728 Kirkwood
Michaelis, Mrs. Stephen C.....1255 Korte Lane
Miller, Mrs. Carl G.....457 Oakdale Dr.
Miller, Mrs. Don E.....5511 Plaza Dr.
Miller, Mrs. Edward D.....2615 East Drive
Miller, Mrs. H. Paul.....6408 S. Calhoun
Miller, Mrs. Mahlon F.....1115 Illsley
Miller, Mrs. Orval J.....1810 Kensington
Miller, Mrs. Richard.....5125 Old Mill Road
Miller, Mrs. Wm. J.....2620 Capitol
Moats, Mrs. Carl F.....3210 N. Washington Rd.
Moeller, Mrs. Victor C.....4723 St. Joe Center Rd.
Moravec, Mrs. Arthur.....4711 Old Mill Rd.
Morey, Mrs. Edwin.....709 Kinnaird
Morgan, Mrs. Milton M.....8214 Park Ridge Dr.
Mortenson, Mrs. Leland J...1310 W. Foster Pkwy.
Mueller, Mrs. Lawrence W. 3423 S. Washington Rd.
Murdock, Mrs. Harvey L.....1212 Kensington

N-O

Nahrwold, Mrs. E. W.....2325 Inwood Dr.
Nill, Mrs. John H.....5316 South Wayne
Nolan, Mrs. Gerald R.....1102 Kensington
O'Brian, Mrs. John F.....1215 N. Anthony Blvd.
O'Rourke, Mrs. Carroll.....9211 Covington Road
Oyer, Mrs. J. Harold.....2206 Wawonaissa

P

Painter, Mrs. Donald S....R. R. 1, Southridge Rd.
Parker, Mrs. C. B.....2215 Paulding Rd.
Patterson, Mrs. Jack W.....8914 Maravilla Dr.
Parrot, Mrs. Donald J.....4926 Chaucer
Perrin, Mrs. Kermit F.....2828 Lake Ave.
Phelps, Mrs. William J.....4136 Cadena Lane
Pickett, Mrs. Merle E.....4509 Trierwood
Popp, Mrs. Milton F.....3148 Parnell Ave.
Powell, Mrs. M. Jack.....7412 Ridge Knoll Rd.
Priddy, Mrs. Marvin.....3902 Bonita Place

R

Rank, Mrs. William B.....3737 S. Washington Rd.
Reed, Mrs. John D.....2130 Hobson Rd.
Rhamy, Mrs. Bonnelle W.....4312 Beaver
Rissing, Mrs. Walter J.....3200 Irvington
Roser, Mrs. Arthur J.....5576 Covington Rd.
Rossiter, Mrs. Dudley L.....724 Oakdale Dr.
Rothberg, Mrs. Maurice.....4319 Hartman Rd.
Rousseau, Mrs. John W.....3018 Devon Dr.

S

Sahlmann, Mrs. Hans.....2402 Woodward
Salon, Mrs. Harry W.....4017 Hiawatha Blvd.
Salon, Mrs. Joel.....4935 Old Mill Road
Salon, Mrs. Nathan L.....7939 Scottwood Court
Sarver, Mrs. Francis E.....4629 Tacoma
Savage, Mrs. Arthur R.....R. R. 1, Southridge Rd.
Schlademan, Mrs. Karl R.....5231 Old Mill Rd.
Schloss, Mrs. Robert....414 W. Sherwood Terrace
Schmidt, Mrs. Eugene E.....1119 Maxine Dr.
Schmoll, Mrs. Robert J.....5214 Woodhurst
Schneider, Mrs. Louis A...1351 W. Sherwood Tr.
Schoen, Mrs. Fred.....5128 S. Wayne
Schoenhals, Mrs. Charles E.....2818 Inwood
Schubert, Mrs. Jerome C...4725 Wellington Drive
Scoins, Mrs. W. H.....4301 Taylor
Scudder, Mrs. James.....1619 Forest Park Blvd.
Senseny, Mrs. Eugene F.....3112 Beaver
Shaw, Mrs. James E.....3932 Rosewood Drive
Shinabery, Mrs. Lawerence.....1850 Broadway
Shugart, Mrs. Robert R...4206 N. Washington Rd.
Sidell, Mrs. James.....1228 Powers
Singer, Mrs. Elmer C.....3121 E. Maple Grove
Smith, Mrs. G. A.....2313 Florida
Smith, Mrs. Philip L.....5416 South Wayne
Snyderman, Mrs. Sanford C...3222 N. Wash. Rd.
Somers, Mrs. G. H.....1253 W. Rudisill
Spencer, Mrs. C. Herbert....2106 Paulding Road
Stanley, Mrs. Robert G.....411 W. Concord Lane
Stauffer, Mrs. Richard C.....3924 Spanish Trail
Steigmeyer, Mrs. David J.....6809 Woodcrest
Stellner, Mrs. Howard A.....3323 Butler Court
Stier, Mrs. Paul.....R. R. 6, 13120 Ravine Trail
Stucky, Mrs. Jerry L.....4167 Woodstock Ave.
Sullivan, Mrs. Robert E.....4145 Woodstock

T

Tennant, Mrs. David L.....3908 Spanish Trail
Terrill, Mrs. Richard.....4727 Old Mill Rd.
Thornton, Mrs. Walter E.....601 Oakdale Dr.
Tomusk, Mrs. August N.....2315 Springfield
Trier, Mrs. Herbert P.....3212 River Forest Dr.

U-V

Ungemach, Mrs. Willo F.....3929 Wenonah
Vogel, Mrs. Lloyd A.....5626 Dartmouth Dr.

W

Wade, Mrs. Reynolds W., Jr...4105 Dalewood Dr.
Walker, Mrs. Floyd.....1202 Forest Ave.
Wallace, Mrs. Collins.....4153 Woodstock
Warfield, Mrs. Chester H.....3924 Harris Rd.
Weber, Mrs. John R.....1215 Sheridan Ct.
Wick, Mrs. Alfred A.....2320 Springfield Ave.
Wilkins, Mrs. Robert W.....914 Prange Dr.
Wilson, Mrs. Leslie.....4864 Reed Rd.
Wilson, Mrs. Roland B.....4100 Abbott
Wright, Mrs. William C.....1834 Pemberton Dr.

Z

Zehr, Mrs. Noah.....301 W. Creighton
Zweig, Mrs. Elmer S.....2015 Pemberton

New Haven

Dahling, Mrs. C. Wallace..Carefree Farms, R. R. 2
Emenhiser, Mrs. Don C.....1040 Lincoln Highway
Hoetzer, Mrs. Eldore M.....Doyle Rd.
Stumpf, Mrs. Edwin E.....R. R. 2, Werling Rd.

Harvey, Mrs. Harry C...Methodist Home, Franklin
Emme, Mrs. Richard W.....R. R. 2, Grabill
Mackel, Mrs. Frederick.....R. R. 1, Huntertown
Harless, Mrs. O. Fred.....Monroeville

Schlegel, Mrs. Edward
2009 Frieze Ave., Ann Arbor, Mich.

BARTHOLOMEW-BROWN COUNTIES

Columbus

Able, Mrs. Walter.....2630 19th St.
Adler, Mrs. David L.....4224 N. Riverside Dr.
Andrews, Mrs. Fred B.....2813 DeSoto Way
Anthony, Mrs. Hubert F. Jr.....1601 Azelea Drive
Beggs, Mrs. Lowell F.....2733 Riverside Dr.
Daugherty, Mrs. Forest.....2813 31st St.
Davis, Mrs. Marvin R.....2300 N. Washington St.
Dugan, Mrs. Thomas.....2651 18th St.
Echsner, Mrs. Herman J.....300 Tipton Lane
Fisher, Mrs. Walter S.....906 Franklin St.
Fuller, Mrs. Robert.....1602 Crescent Dr.
Gammell, Mrs. Lindley L.....602 22nd St.
Hart, Mrs. Robert B.....1203 16th St.
Hauersperger, Mrs. Alfred D.....4164 River Rd.
Hawes, Mrs. Marvin E.....2975 Franklin Dr.
Henry, Mrs. Alvin L.....1926 Lafayette Avenue
Jacobs, Mrs. E. Robert.....2335 Riverside Dr.
Knotts, Mrs. Halleck S.....2740 Washington St.
Krueger, Mrs. Robert B.....2102 Lafayette Ave.
Macy, Mrs. George W.....2623 Riverside Dr.
Marr, Mrs. Griffith.....Marr Rd., R. R. 1
McCullough, Mrs. Henry G.
Old Indianapolis Rd., R. R. 4
Mohler, Mrs. Floyd W.....308 Sunset Dr.
Norton, Mrs. Harold J.....909 Pearl St.
O'Bryan, Mrs. Richard B...3306 Grove Parkway
Overshiner, Mrs. Lyman.....1715 Franklin St.
Ranck, Mrs. Benjamin A.....3370 Grove Parkway

Rau, Mrs. Charles A.....1312 Audubon Dr.
Reid, Mrs. Robert M.....2712 Lafayette Ave.
Richmond, Mrs. Harold W.....2971 Tulip Dr.
Ryan, Mrs. Wm. J.....3224 Grove Parkway
Schmitt, Mrs. Richard K.....2639 Riverside Dr.
Sigmund, Mrs. Wm. B.....Davis Road
Snapp, Mrs. Richard A.....2644 Chestnut St.
Weinland, Mrs. George C.....R. R. 5
Wickstrom, Mrs. Otto W.....205 Newsom
Wigh, Mrs. Russell.....2767 Lafayette Ave.
Williams, Mrs. E. W.....1902 Franklin St.
Zaring, Mrs. Byron K.....2419 Riverside Dr.

Schneider, Mrs. Kenneth D.....Nashville
Seibel, Mrs. Robert M.....Nashville

BENTON COUNTY

Coddens, Mrs. A. L.....Box 342, Earl Park
Leak, Mrs. Robert.....Boswell
McKinney, Mrs. Donald L.....Box 398 Otterbein
Scheurich, Mrs. Virgil..State Rd. 55 South, Oxford

BOONE COUNTY

Lebanon

Boyer, Mrs. Don.....129 W. Camp
Coons, Mrs. John D.....121 Ulen Blvd.
Coons, Mrs. Ritchie.....138 Ulen Blvd.
Honan, Mrs. Paul.....202 East Dr.
Kern, Mrs. Clarence G.....1019 N. Meridian
Lenox, Mrs. Jack.....203 East Dr.
McAfee, Mrs. James.....1997 Terrace Lane
Weddle, Mrs. Charles O.....1210 N. East
Wiseheart, Mrs. Robert H.....123 Ulen Blvd.

Schaaf, Mrs. Alvin D.....Jamestown
Gregg, Mrs. Edwin.....320 E. Main, Thorntown
Harvey, Mrs. Ralph.....Zionsville
Lovett, Mrs. Harvey D.....R. R., Zionsville

CARROLL COUNTY

Delphi

Baker, Mrs. Eldon E.....204 W. Summit St.
Crampton, Mrs. Chas. C.....218 E. Monroe St.
Maggart, Mrs. Ralph.....R. R. 3
Petry, Mrs. T. Neal.....211 W. North St.
Seese, Mrs. Robert M.....201 W. North St.
Wagoner, Mrs. Geo. W.....305 W. Summit St.

Adams, Mrs. Max R.....Park Row, Flora
McLaughlin, Mrs. James R.....511 E. Main, Flora

CASS COUNTY

Dutchess, Mrs. Charles T.....Galveston

Logansport

Adamski, Mrs. M. S.....614 17th St.
Bailey, Mrs. Earl W.....2522 North
Ballard, Mrs. Charles A.....R. R. 4, Ballard Rd.
Bean, Mrs. Joseph S.....R. R. 1, Box 167
Burnett, Mrs. Paul C.....Logansport State Hosp.
Davis, Mrs. John C.....2119 North
Eckert, Mrs. Russell A.....R. R. 1
Fitzgerald, Mrs. Brice.....1930 High
Fogel, Mrs. Ernest J...Logansport State Hospital
Gatzimos, Mrs. Christos D.....3116 High St. Rd.
Glendening, Mrs. Richard L.....2300 Broadway
Hall, Mrs. Bernard R.....3100 E. Broadway
Harrington, Mrs. James F.....2316 Rolling Ridge
Hedde, Mrs. Eugene L.....2304 Chase Rd.
Hillis, Mrs. L. J.....2410 Hastye Hyll
Horning, Mrs. Richard R.
Logansport State Hospital
Jones, Mrs. J. Carl.....R. R. 3
King, Mrs. Jay M.....2319 Mayfair Dr.
Maschmeyer, Mrs. R. H.
Logansport State Hospital
Morrical, Mrs. Russell J.....415 Highland
TerBush, Mrs. Edward L.....R. R. 5
Viney, Mrs. Charles L.....26th and High St.
Wilson, Mrs. Paul H.....2600 Hastye Hyll
Winter, Mrs. Donald K.....2409 Hastye Hyll

Flanagan, Mrs. E. P.....106 May, Walton
Lybrook, Mrs. Daniel E.....Young America

CLARK COUNTY

Charlestown

Goodman, Mrs. Eli.....333 Oriole Dr.
Jones, Mrs. David.....State Road 39

Clarksville

Mudd, Mrs. Joseph.....103 Rosewood Dr.
Willner, Mrs. Alan.....214 Rosewood Dr.
Wolverton, Mrs. George.....115 Rosewood Dr.

Jeffersonville

Bizer, Mrs. Mier.....119 Forrest Dr.
Buckley, Mrs. Ernest.....14 Blanchel Terrace
Buehler, Mrs. George.....Route 1, Utica Pike
Carlberg, Mrs. Dale L.....2 Blanchel Terrace
Carney, Mrs. J. T.....2602 Hollywood Dr.
Clark, Mrs. William B.....Blackiston Mill Road
Dare, Mrs. Lee.....215 Sparks Ave.
Graham, Mrs. O. P.....713 E. Maple St.
Green, Mrs. Frank, Jr.....Kewanna Drive
Havens, Mrs. Alfred Lyle.....Utica Pike
Huoni, Mrs. John.....6 Blanchel Terrace
Isler, Mrs. Nathaniel C.....901 Morningside Dr.
McKechnie, Mrs. Robert K.....Blackiston Mill Rd.
Oca, Mrs. Clemente F.....1452 Altawood Dr.
Reed, Mrs. Edsel.....4 Pawnee Dr.
Roby, Mrs. A. L.....Rt. 9, Box 91, Utica Pike
Shaw, Mrs. Houston.....209 Maplewood Dr.

Sellersburg

Meyer, Mrs. Claude J.....225 W. Utica St.
Regan, Mrs. George.....303 Indiana
Sturgis, Mrs. Donald G.....542 Linnwood
Vandevert, Mrs. Arthur.....202 Highland

Carr, Mrs. Joseph.....Pine Rd., Henryville
Greene, Mrs. W. R.....Henryville
Horlander, Mrs. Fridolin.....Henryville

DEARBORN COUNTY

Aurora

Baker, Mrs. Leslie M.....204 Fifth St.
Frable, Mrs. Frank.....412 Sunnyside Ave.
Gresham, Mrs. Edwin.....Ebenezer Rd.
Jackson, Mrs. Kenneth.....221 Mechanic St.
Lindgren, Mrs. Ivan.....Cobbs Hill
Olcott, Mrs. Charles W.....305 Sunnyside

McNeely, Mrs. Matthew J.....Dillsboro
Fessler, Mrs. Gordon.....Rising Sun

Lawrenceburg

Bowen, Mrs. Gerald 24 Parkside Ave.
Conrad, Mrs. Henry.....370 Bielby Rd.
Houston, Mrs. Fred D.....533 Ludlow St.
Hunter, Mrs. Lowell.....2 Clinic Dr.

Morrison, Mrs. George.....107 Billups
Pfeifer, Mrs. James M.....550 Ludlow
Rhodes, Mrs. A. Keith.....Loretta Ave.
Stahl, Mrs. Norman.....950 Pribble Circle
Streck, Mrs. Francis A.....547 Ridge Ave.
Weisenberger, Mrs. Brockton L.....912 Bielby Dr.

DECATUR COUNTY

Greensburg

Acher, Mrs. Robert P.....446 E. Washington
Callaghan, Mrs. W. C.....403 Barachel Lane
Dickson, Mrs. Dale D.....700 N. East St.
Miller, Mrs. James C.....178 N. Michigan Ave.
Morrison, Mrs. J. Trevor....161 N. Michigan Ave.
Overpeck, Mrs. Charles.....R. R. 8
Shaffer, Mrs. William R.....214 N. Franklin
Walker, Mrs. Louis A.....R. R. 5

Porter, Mrs. Edward.....Westport

DELAWARE-BLACKFORD COUNTIES

Hurley, Mrs. John.....Daleville
Puterbaugh, Mrs. Karl.....Albany
Montgomery, Mrs. Lall G.
Box 149A, RFD 1, Gaston
Doles, Mrs. Ted.....1102 Progress, Middletown
Egger, Mrs. Ross.....603 N. 12th, Middletown
Owsley, Mrs. Guy.....The Oaks, Hartford City

Muncie

A

Adams, Mrs. William B.....W. Jackson St. Pike
Alvey, Mrs. Charles R.....515 Greenbriar Rd.
Anthony, Mrs. Harvey M.....822 W. Charles

B

Ball, Mrs. Clay A.....1015 Linden Ave.
Ball, Mrs. Philip.....2820 W. Main St.
Benken, Mrs. Lawrence.....1511 Riley Rd.
Bergwall, Mrs. Warren.....1507 Riley Rd.
Bibler, Mrs. Henry.....2625 Parkway Dr.
Botkin, Mrs. Clyde G.....2904 Riverside Ave.
Botkin, Mrs. Thomas.....2500 Bethel Pike
Brown, Mrs. Leland.....605 Waid Ave.
Brown, Mrs. Stewart D...R. R. 3, Hamilton Pk.
Brown, Mrs. Thomas.....R. R. 6, Box 191
Burwell, Mrs. Stanley W.....3124 Gilbert
Butterfield, Mrs. Robert.....222 Winthrop Rd.
Butz, Mrs. Ralph O.....3824 Riverside Ave.

C

Clark, Mrs. Robert.....911 University Ave.
Clauser, Mrs. Eldo H.....815 Wayne
Clevenger, Mrs. Joseph H...3124 University Ave.
Cochran, Mrs. Robert.....1 Briar Rd.
Cooper, Mrs. John F.....1700 Winthrop Dr.
Covalt, Mrs. Wendell E.....120 Berwyn Rd.
Cullison, Mrs. John.....2601 Parkway Dr.
Cure, Mrs. Elmer T.....913 University Ave.

D

David, Mrs. George.....1501 Wheeling Ave.
Deutsch, Mrs. William.....3305 Riverside Ave.
Dietz, Mrs. David J.....501 Shellbark
Dunning, Mrs. Thomas.....3 Briar Rd.

E-F

Fiederlein, Mrs. Frederick.....308 Wildwood

G

Garling, Mrs. L. C.....37 Briar Rd.
Geckler, Mrs. Charles E.....1007 W. North St.
Gibson, Mrs. Robert.....306 Taft Rd.
Gill, Mrs. Thomas A., Jr.....45 Warwick Rd.
Greiber, Mrs. Marvin.....310 Riley Rd.
Gustafson, Mrs. Milton H.....230 Stradling Rd.

H-I

Hall, Mrs. Robert S.....701 Brentwood
Hayes, Mrs. T. R.....19 Warwick Rd.
Henderson, Mrs. Ramon.....75 Warwick Rd.
High, Mrs. Ralph.....2825 University Ave.
Holmes, Mrs. John.....908 W. Gilbert
Hostetter, Mrs. I. S.....300 Winthrop Rd.
Imhof, Mrs. J. D.....46 Warwick Rd.

K-L

Kalker, Mrs. Morton.....704 Greenbriar Rd.
Kammer, Mrs. Walter F.....1005 W. Parkway Dr.
Kim, Mrs. Joon.....1308 Riley Rd.
Kirshman, Mrs. Forrest E.....41 Briar Rd.
Ko, Mrs. Richard.....R. R. 7
Koch, Mrs. Edwin F., Jr.....2904 Ashland
Koss, Mrs. K. William.....1504 Riley Rd.
Kress, Mrs. James W.....1111 Riverside Ave.

M-N

Mathewson, Mrs. R. C.....R. R. 6
McClintock, Mrs. James A...3121 University Ave.
McDowell, Mrs. Fletcher W.....1721 N. Tillotson
Moore, Mrs. Jack.....2005 W. Purdue
Moore, Mrs. Thomas C.....1011 E. Parkway Dr.
Morris, Mrs. J. W.....222 Stradling Rd.
Moss, Mrs. M. J.....1010 W. Parkway Dr.
Nelson, Mrs. Harold E.....3216 Torquay Rd.

O

Osborne, Mrs. John.....3125 Petty Road
Owens, Mrs. Thomas.....608 E. Charles

P-Q

Peacock, Mrs. Robert.....R. R. 3
Pippinger, Mrs. Joseph.....1308 Riley Rd.
Pippinger, Mrs. W. G.....1200 N. Tillotson
Quick, Mrs. William J.....Moore Rd.

R

Rettig, Mrs. Arthur.....614 N. McKinley Ave.
Rivers, Mrs. Glynn.....307 Alden Rd.

S

Schulhof, Mrs. M. G.....921 W. Parkway Dr.
Smith, Mrs. J. S.....1006 E. First St.
Speck, Mrs. Carlson.....1205 Brentwood
Steele, Mrs. Frank M.....421 Bittersweet
Stibbins, Mrs. Warren E.....609 Brentwood
Stout, Mrs. Francis E.....102 Berwyn Rd.
Stump, Mrs. Richard.....1304 Bethel

T

Taylor, Mrs. Donald.....8 Wildwood Lane
Taylor, Mrs. James A.....1613 Riley Rd.
Tharp, Mrs. Donald.....3121 Petty Rd.
Tomlin, Mrs. Hugh M.....2920 Beechwood Ave.

V-W

Voss, Mrs. Gert.....2512 Petty Rd.
Walker, Mrs. Jack.....R. R. 6, Box 385A
Ware, Mrs. Herbert.....1700 Glen Ellyn

Y

Young, Mrs. G. S.....114 Berwyn Rd.

Hinchman, Mrs. Jean.....Parker
Hill, Mrs. Robert.....Yorktown
Moore, Mrs. Will C...White Oak Farm, Yorktown
Rutledge, Mrs. Jean.....R. R. #1, Yorktown

DUBOIS COUNTY

Barrow, Mrs. John H.....Dale, P. O. Box 128
Backer, Mrs. Henry George..Ohio St., Ferdinand
Bland, Mrs. Jack D.....Holland

Huntingburg

Amini, Mrs. Sohrab.....R. F. D. #2
Bretz, Mrs. John.....Orchard Ridge
Craig, Mrs. Harry.....Fifth St.
Scales, Mrs. Alfred B.....Holland Rd.
Scales, Mrs. Allen D.....Cedar Heights
Stork, Mrs. Harvey K.....523 First St.

Jasper

Beaven, Mrs. John.....W. 13th St.
Benages, Mrs. Anthony.....948 MacArthur
Gootee, Mrs. Francis.....R. R. 1
Gootee, Mrs. Thomas.....1328 Dorbett St.
Heck, Mrs. Martin C.....408 W. 15th
Held, Mrs. George A.....716 W. Ninth
Klamer, Mrs. Charles H.....616 W. 13th St.
Ploetner, Mrs. Edward.....1344 Dorbett St.
Salb, Mrs. J. P.....R. R. 5
Wagner, Mrs. Arthur L.....825 W. 13th St.

ELKHART COUNTY

Bristol

Neidballa, Mrs. E. G.....R. R. 1
Schlosser, Mrs. H. C.
Seven Gables, W. Vistula St., Box 57

Elkhart

Atwood, Mrs. Wm. H., Jr.....320 Cedar St.
Bender, Mrs. Robert L.....300 Robair Lane
Benson, Mrs. James E...1629 Rainbow Bend Blvd.
Billings, Mrs. Elmer R.....2022 E. Jackson Blvd.
Bloom, Mrs. George R.....1100 E. Jackson Blvd.
Boling, Mrs. Richard C.....217 Riverdale Dr.
Bowdoin, Mrs. George E.....3809 Greenleaf Blvd.
Campbell, Mrs. Patrick B.....1618 Cone St.
Classen, Mrs. Pete R. C...Prairie St. Road, R.R. 4
Compton, Mrs. Walter A.....2225 Greenleaf Blvd.
Conklin, Mrs. Raymond L...215 Swanson Circle W.
Cormican, Mrs. Herbert L.
1950 Rainbow Bend Blvd.
Dovey, Mrs. Edward G., Jr...1604 Springbrook Dr.
Durham, Mrs. Thomas E.....135 S. Vine St.
Echeverria, Mrs. Rodolfo E.....707 Hiawatha Dr.
Elliott, Mrs. Thomas A.....2001 Stevens Ave.
Finfrock, Mrs. James D.....608 S. West Blvd.
Fleming, Mrs. Claude F.....229 W. Jackson Blvd.
Futterknecht, Mrs. James O...2313 Morehouse Ave.
Gattman, Mrs. G. Beach.....1319 Lawn Ave.
Hannah, Mrs. Jack W.....1906 E. Jackson Blvd.
Heminway, Mrs. Norman L.
1700 Rainbow Bend Blvd.
Horswell, Mrs. R. G.....1629 E. Jackson Blvd.
Hull, Mrs. Arthur W.....3333 Greenleaf Blvd.
Hurley, Mrs. James William.....3439 Calumet
Ivy, Mrs. John H.....1311 Kilbourn St.
Jones, Mrs. Robert B.....1833 Rainbow Bend Blvd.
Keating, Mrs. John U.....1416 Strong Ave.
Kesim, Mrs. Mufit Husam.....821 Hiawatha Dr.
Kielton, Mrs. Melvyn.....2509 Pleasant Plain
Kintner, Mrs. Burton E.....3520 E. Jackson Blvd.
Kistner, Mrs. Arthur W.....R. R. 3, Box 81
Klassen, Mrs. Otto Dyck.....R. R. 4, Box 504
Koehler, Mrs. Elmer George..615 N. Riverside Dr.
Krause, Mrs. Friedrich.....1001 St. Clair St.
Luther, Mrs. William C.....1422 Kilbourn St.
Lundt, Mrs. Milo O.....519 S. Second St.
Mark, Mrs. George Arthur....903 W. Franklin St.
Markel, Mrs. Ivan J.....215 W. Franklin St.
Martin, Mrs. Paul H.....1519 Strong Ave.
McArt, Mrs. Bruce A.....905 Strong Ave
Miller, Mrs. Donald G.....4634 W. Indiana Ave.
Miller, Mrs. Galen R.....2229 Thorndale Ct.
Miller, Mrs. Hugh A., Jr.....417 Prospect St.
Miller, Mrs. James R.....306 W. Waterford St.
Miller, Mrs. Samuel T.....174 Witmer Ave.
Mininger, Mrs. Edward P...1118 E. Jackson Blvd.
Mishkin, Mrs. Irving....1809 Rainbow Bend Blvd.
Paff, Mrs. Wm. A.....1745 Rainbow Bend Blvd.
Paine, Mrs. George E.....329 Meisner Ave.
Pancost, Mrs. Vernon K.....160 Riverview Ave.
Parshall, Mrs. Dale B.....3538 Gordon Rd.
Pletcher, Mrs. William D.....350 Hiawatha Dr.
Rouen, Mrs. Robert L.....2002 E. Jackson Blvd.
Rupe, Mrs. Lloyd O.....R. R. 4, Oakland Ave. Rd.
Rupel, Mrs. Dennis F.....3100 Benham Ave.
Sears, Mrs. Murray M.....4806 W. Indiana Ave.
Silber, Mrs. David L.....1501 Fulton St.
Sobol, Mrs. Zbigniew W.....433 East Blvd.
Spray, Mrs. Page E.....658 Kilbourn St.
Stubbins, Mrs. William.....15 St. Joseph Manor
Swihart, Mrs. Danny D.....1219 Greenleaf Blvd.
Swihart, Mrs. Homer R.....1621 E. Jackson Blvd.
Wilson, Mrs. Orley E.....2505 Greenleaf Blvd.
Work, Mrs. James A., Jr.....4 St. Joseph Manor
Yoder, Mrs. C. Richard.....409 Prospect St.
Yoder, Mrs. Jonathan G.....103 Brown St.
Zeitler, Mrs. Philip S.....1509 Meadow Lane

Goshen

Bender, Mrs. John M.....1303 E. Douglas St.
Chandler, Mrs. Leon H.....412 S. Fifth St.
Freeman, Mrs. Floyd M.....309 E. Washington St.
Gorham, Mrs. Charles E.....2105 College Ave.
Graber, Mrs. Virgil R.....R. R. 2, Box 107
Haney, Mrs. Leslie.....R. R. #3
Harris, Mrs. Neil R.....628 S. Fifth St.
Hostetler, Mrs. Carl M.....1602 S. Eighth St
Kennedy, Mrs. Myron S.....1503 West Ave.
Krabill, Mrs. Willard S.....120 Carter Ave.
Martin, Mrs. Floyd S.....2301 S. Main St.
Massanari, Mrs. Walter S..2613 Martin Manor Dr.
Nelson, Mrs. D. Chester.....1210 S. Eighth St.
Smucker, Mrs. Ernest E.....R. R. 5, Bluff Rd.
Troyer, Mrs. Dana O.....1727 S. 13th St.
Troyer, Mrs. George W.....1204 S. 8th St.
Turner, Mrs. John P.....507 Greene Road
Wagner, Mrs. David G.....307 S. Seventh St.
Westfall, Mrs. George S.....2422 S. Main St.
Yoder, Mrs. Albert C.....816 S. Sixth St.

Nappanee

Kendall, Mrs. F. M.....654 Woodland
Slabaugh, Mrs. Jancy S.....258 N. Main St.

Quilty, Mrs. Thomas J.....R. R. 1, New Paris
DeFries, Mrs. John J.....New Paris
Fosbrink, Mrs. E. L.....218 S. Huntington,
Box 157, Syracuse
Zimmerman, Mrs. William H.
R. R. 2, Box 31, Syracuse

Wakarusa

Abel, Mrs. Robert.....105 E. Harrison
Guttman, Mrs. John B.....201 N. Elkhart Ave.

FAYETTE-FRANKLIN COUNTIES

Brookville

Foreman, Mrs. Walter A.....617 Main
Seal, Mrs. Perry F.....901 Main
Smith, Mrs. H. N.....812 Main

Connersville

Ashworth, Mrs. Louis N.....2027 Indiana Ave.
Brookman, Mrs. Robert E.....2750 Grand Ave.
Clark, Mrs. Helen Nevin.....401 Western Ave.
Ellis, Mrs. George M.....108 East 10th St.
Gregg, Mrs. Albert F.....900 Oak St.
Hudson, Mrs. Arlington M.....80 East Dr.
Kauffman, Mrs. Robert W.....R. F. D. 2

Lockhart, Mrs. Jack M.....54 West Dr.
Mountain, Mrs. Francis B.....1720 Virginia Ave.
Neukamp, Mrs. Frank H.....R. R. 6
Sanders, Mrs. Bertram W.....1533 Virginia Ave.
Steinem, Mrs. Joseph L.....R. R. 3
Watterson, Mrs. Gerald T.....1704 Virginia Ave.

Poston, Mrs. C. L.....R. R. 2, Laurel

FLOYD COUNTY

Jeffersonville

Baxter, Mrs. S. M.....3100 Centralia Ct.
Gentile, Mrs. John P.....3495 Centralia Ct.
McCullough, Mrs. J. Y.....3500 Centralia Ct.
Sloan, Mrs. Herbert.....213 Lynnwood, Lincoln Heights

New Albany

Baker, Mrs. A. M.....2523 Glenwood Ct.
Baxter, Mrs. J. W., Jr.....426 Woodrow Ave.
Best, Mrs. Maurice M.....1233 Vance Ave.
Brown, Mrs. K. H.....1654 Hedden Park
Buchman, Mrs. Marshall.....1824 State St.
Cannon, Mrs. Daniel H.....1203 E. Spring St.
Edwards, Mrs. W. F.....615 Beharrel Ave.
Garner, Mrs. Wm. H., Sr.....922 E. Spring St.
Garner, Mrs. William H., Jr.....1510 Sunset Dr.
Geyer, Mrs. Joseph H.....Silvercrest Hospital
Harris, Mrs. Robert W.....1923 Ekin Ave.
Hess, Mrs. P. Patrick.....1313 Ridgeway Ave.
Higgins, Mrs. John R.....Old Vincennes Rd.
LaFollette, Mrs. Donald R...1224 Westwood Lane
LaFollette, Mrs. Robert E.....2515 Glenwood Ct.
Nedelkoff, Mrs. Bogdan.....R. R. 2, Box 500
Paris, Mrs. John M.....2003 Lindbergh Ct.
Robertson, Mrs. A. N.....323 E. Ninth St.
Sonne, Mrs. Irvin H.....1607 Hedden Court
Streepey, Mrs. Jefferson I.....1919 DePauw Ave.
Voyles, Mrs. Harry.....425 Beharrel Ave.
Weaver, Mrs. W. W.....905 E. Elm, Apt. #8
Wolfe, Mrs. Morton F.....2533 Glenwood Ct.
Wolfe, Mrs. Nelson A.....Graybrook Lane
Worley, Mrs. H. L.....1923 DePauw Ave.

Bickers, Mrs. Everett E.....3325 Buffalo Trails, Floyd Knobs
Engleman, Mrs. Harry K.....Georgetown

FULTON COUNTY

Miller, Mrs. Virgil C.....P. O. Box 37, Akron
Stinson, Mrs. Arthur E.....Athens
Kraning, Mrs. Kenneth K.
834 West Shore Dr., Culver

Rochester

Dielman, Mrs. Franklin C.....920 Jefferson St.
Herendeen, Mrs. Elbie V.....317 W. Seventh St.
King, Mrs. Milo O.....110½ E. Eighth St.
Knockel, Mrs. Wayne.....1115 Washington St.
Richardson, Mrs. Chas. L.....R. R. 2, Box 276
Richardson, Mrs. Joseph D.....506 Pontiac St.
Rowe, Mrs. Howard H.....417 W. Ninth St.
Rusler, Mrs. William J.....R. R. 2
Stinson, Mrs. Dean K.....1318 Main St.

GIBSON COUNTY

Geick, Mrs. Raymond G...207 N. Main, Ft. Branch
Kenshol, Mrs. William S...307 S. Mill, Owensville
Marchand, Mrs. Edwin V.....Haubstadt

Oakland City

Clark, Mrs. Carl M.....123 Vine St.
Dye, Mrs. William E.....518 S. Jackson St.
Wood, Mrs. Russell W.....High St.

Princeton

Carpentier, Mrs. Harry F.....319 E. State St.
Folck, Mrs. John K.....528 N. Main St.
Graves, Mrs. Orville M.....125 W. Walnut St.
McCarty, Mrs. Virgil.....403 W. Spruce St.
McElroy, Mrs. Robert S.....404 W. Walnut St.
Peck, Mrs. James F.....605 W. Monroe St.
Weitzel, Mrs. Roland E.....309 W. Spruce St.
Wells, Mrs. William R.....Broadview Addition

GRANT COUNTY

Marion

Abell, Mrs. Charles F.....915 Wabash Ave.
Abell, Mrs. Charles F. Jr.....717 Jeffras Ave.
Alderfer, Mrs. Henry.....919 Euclid Ave.
Ayres, Mrs. W. W.....820 Jeffras Ave.
Bailey, Mrs. Douglas.....1316 Elm Lane
Bloom, Mrs. A. Ward.....610 River Rd.
Braunlin, Mrs. Robert.....P.O. Box 467
Brown, Mrs. Robert M.....825 Euclid Ave.
Comeau, Mrs. Wm. J.....918 Hawthorne
Cunningham, Mrs. Robert.....1017 Euclid Ave.
Davis, Mrs. Joseph B.....1315 Sheridan Rd.
Donaldson, Mrs. Miles.....1116 Spencer Ave.
Dunbar, Mrs. Fred.....902 Hawthorne Rd.
Fisher, Mrs. Henry.....R. R. 4
Fuelling, Mrs. James.....Bocock Rd.
Ganz, Mrs. Max.....904 Jeffras Ave.
Goldsmith, Mrs. David.....1225 Jeffras Ave.
Hover, Mrs. Galen M.....27 A Veterans Hosp.
Hummel, Mrs. R. M.....2411 Lommel Lane
Jarrett, Mrs. John C.....3418 Wildwood Dr.
Lahr, Mrs. Richard E.....1121 W. Third St.
Langrall, Mrs. Harrison M.....715 Crossway
Lavengood, Mrs. Russell W.....Charles Rd. R. R.
Lonngren, Mrs. Dudley.....611 Cardinal Lane
Love, Mrs. V. Logan.....808 Crossway
Miller, Mrs. H. Allison.....1010 W. Fourth St.
Pattison, Mrs. John D.....1315 Elm Lane
Pearcy, Mrs. Marcene.....3116 Coats Rd.
Powell, Mrs. J. P.....127 River Dr.
Price, Mrs. Ambrose M.....2938 S. Branson St.
Reid, Mrs. James D.....505 Buckingham Dr.
Renbarger, Mrs. Lester.....2111 Wabash Pike
Rhamy, Mrs. Arthur.....1230 Euclid Ave.
Rhorer, Mrs. John G.....711 Wabash Ave.
Richardson, Mrs. Jos. H.....911 River Dr.
Schroeder, Mrs. Robert W.....2123 S. Boots St.
Simmons, Mrs. Frederick H.....2607 Beech Lane
Skomp, Mrs. Claud E.....1123 Euclid Ave.
Smith, Mrs. Barton T.....1005 Audubon Dr.
Stenger, Mrs. R. H.....227 North E. St.
Thompson, Mrs. B. Jay.....123 River Dr.
Thompson, Mrs. John R...James St., Rolling Hills
Walton, Mrs. R. Lee.....1019 Lincolnshire Blvd.
Warren, Mrs. Carroll B.....1211 Euclid Ave.
Weinberg, Mrs. Samuel.....905 Euclid Ave.
Wilson, Mrs. Ned.....1134 W. Third St.
Woodbury, Mrs. J. W.....711 W. Nelson St.
Young, Mrs. Robert G.....1207 Northwood Dr.

Malott, Mrs. Fred.....Converse
Grant, Mrs. Arthur..501 W. 3rd St., Fairmount
Yale, Mrs. Charles.....Fairmount
Garrison, Mrs. L. J.....515 E. Main St., Gas City
Koontz, Mrs. William A.....334 E. Main, Gas City
Shoemaker, Mrs. Richard L.....211 E. South "A," Gas City
Baskett, Mrs. R. J.....412 S. Main St., Jonesboro
Ansbacher, Mrs. Stefan....R. R. 1, La Fontaine
Beck, Mrs. Thomas.....Box 218, Swayzee
Taylor, Mrs. E. C.....Upland
McIlwain, Mrs. Robert.....Warren

HAMILTON COUNTY

Karlick, Mrs. Joseph R.....Arcadia
Thomas, Mrs. W. Clayton
80 4th Ave. S.E., Carmel
Havens, Mrs. Oscar.....R. R. 1, Cicero
Long, Mrs. Malcolm
7605 Westfield Blvd., Indianapolis 40

Noblesville

Ambrose, Mrs. J. C.....298 N. Ninth St.
Blackburn, Mrs. Howard..14010 Allisonville Rd.
Campbell, Mrs. Sam W.....R. R. 1
Hash, Mrs. John S.....R. R. 4
Haywood, Mrs. John G.....1260 Lincoln Dr.
Kraft, Mrs. Haldon C.....15075 Allisonville Rd.
Lanning, Mrs. R. Adrian.....R. R. 2
Lloyd, Mrs. Joe R.....559 Sunset Dr.
Shanks, Mrs. Ray W.....14050 Allisonville Rd.

Manhart, Mrs. Doyle B.....R. R. 2, Sheridan
Newby, Mrs. Eugene.....R. R. 1, Sheridan
Waitt, Mrs. Paul.....406 E. Fifth St., Sheridan
Connoy, Mrs. Andrew.....Westfield
Connoy, Mrs. Leo....139 N. Union St., Westfield

HANCOCK COUNTY

Johnston, Mrs. W. R.....Charlottesville
Scott, Mrs. Robert.....Charlottesville
Rhynearson, Mrs. Hal R...235 Merrill St., Fortville

Greenfield

Allen, Mrs. Joseph.....210 E. Lincoln
Beeson, Mrs. Wilbur.....209 N. Penn
Endicott, Mrs. Wayne.....115 McClelland
Farrell, Mrs. John J., Jr.....North St., Rd. 9
Hunter, Mrs. Donn R.....830 Oak Blvd.
Kinneman, Mrs. Robert E.....120 McClelland Dr.
Kirby, Mrs. Ted C.....122 Grandison Rd.
Smith, Mrs. John H.....919 Maple Dr.
Vingis, Mrs. Bronie A.....705 N. State St.
Woods, Mrs. James R.....715 N. East St.

Garrison, Mrs. James.....Cumberland
Freeborn, Mrs. Warren
11626 Indian Creek Rd., Indianapolis
Pierson, Mrs. Thomas A.....New Palestine
Cagle, Mrs. Robert.....New Palestine
Miller, Mrs. Joseph A.....R. R. 12, Box 230 Y, Oaklandon
Kuhn, Mrs. Robert.....Wilkinson

HENDRICKS COUNTY

Black, Mrs. James...Green Acre Ct., Brownsburg
Foltz, Mrs. Lloyd.....North Ridge, Brownsburg
Scudder, Mrs. A. N.....24 N. Grant, Brownsburg
Walker, Mrs. Thomas..Fairfield Hts., Brownsburg

Danville

Chase, Mrs. Thomas P.....R. R. 1, Box 117-C
Cheesman, Mrs. Donald D.....R. R. 3, Box 271
Gibbs, Mrs. Joseph W.....445 E. Mill St.
Heinlein, Mrs. Carl L.....540 S. Cross
Kirtley, Mrs. Robert W.....R. R. 3, Box 196
Koch, Mrs. Elmer.....301 S. Bowen
Terry, Mrs. Lloyd.....292 W. Marion

Ellis, Mrs. L. Hall.....Lizton
Karpel, Mrs. Bernard.....R. R., Mooresville
Scamahorn, Mrs. Malcolm O.....Pittsboro
Scamahorn, Mrs. Oscar T.....Pittsboro

Plainfield

Aiken, Mrs. Milo M.....140 N. Center
Cohen, Mrs. Irving.....645 E. Main St.
Haggard, Mrs. David B.....R. R. 2, Box 232
Roller, Mrs. Mac C.....68 Price Road, R. R. 2
Stafford, Mrs. William C.....625 S. East St.
Warbinton, Mrs. Fred P.....680 Avon Rd.

HENRY COUNTY

New Castle

Amos, Mrs. Robert L.....924 Lincoln Ave.
Balcom, Mrs. Francis.....2003 Wuthering Dr.
Bitler, Mrs. Clyde.....603 S. 11th St.
Bledsoe, Mrs. James.....Hillsboro Rd.
Brock, Mrs. J. T.....St. Rd. 36 East
Burnett, Mrs. Arthur B.....801 Melody Lane
Cain, Mrs. David R.....3701 S. Memorial Dr.
Craig, Mrs. Alex F.....415 Raintree Dr.
Das, Mrs. Amal K.....100 Van Nuys Rd.
Davies, Mrs. Robert R.....1125 Audubon Rd.
Dye, Mrs. Cloyd L.....R. R. 5
Easter, Mrs. James N.....2136 W. Raintree Dr.
Fisher, Mrs. John E.....1135 Woodlawn Dr.
Foster, Mrs. Ray T.....420 N. Main St.
Harrison, Mrs. Benjamin L.....233 Bundy Ave.
Heilman, Mrs. William C., Jr..1112 St. James Ct.
Iterman, Mrs. George.....729 I Ave.
Kennedy, Mrs. W. U.....701 S. 14th St.
Life, Mrs. Homer L.....1107 St. James Ct.
McClelland, Mrs. Harry N.....New Castle
McDonald, Mrs. Frank C.....527 S. Main St.
McElroy, Mrs. James S.....1213 Audubon Rd.
McKee, Mrs. Roy.....Parkplace
Murray, Mrs. William E.....100 Van Nuys Rd.
Saint, Mrs. William.....705 Hawthorn Rd.
Smith, Mrs. Mark.....631 S. 11th St.
Steussy, Mrs. Calvin N.....601 Hoosier Dr.
Stout, Mrs. Walter M.....1103 Audubon Rd.
Stricker, Mrs. Paul J.....719 Fair Oaks Dr.
Thorne, Mrs. Charles E.....1225 Audubon Rd.
Vivian, Mrs. Donald E.....2715 Fair Oaks Dr.
Wiggins, Mrs. D. S.....219 S. 12th St.

Clark, Mrs. M. E.....Cambridge City
Hollenberg, Mrs. A. E.
105 N. Franklin St., Hagerstown
Wiatt, Mrs. Leonard H.
108 N. Wash. St., Knightstown
Scheetz, Mrs. Marion R.....Lewisville
Stauffer, Mrs. George E.....Mooreland
Marshall, Mrs. Lloyd....Walnut St., Mt. Summit
Robertson, Mrs. William S.....213 W. Main St., Spiceland

HOWARD COUNTY

Smith, Mrs. Charles..R. R. 1, Box 652M, Carmel
Denton, Mrs. Larkin D....S. Meridian, Greentown
Shoup, Mrs. E. M.....R. R. 2, Willow Acres, Greentown

Kokomo

Adams, Mrs. C. J.....1216 W. Superior
Althoff, Mrs. William.....2501 S. Wabash
Alward, Mrs. J. H.....401 W. Walnut
Artis, Mrs. Myrle E.....910 E. Broadway
Ault, Mrs. Carl H.....3015 Dellwood Dr.
Boughman, Mrs. Joe.....1610 W. Taylor
Bowers, Mrs. Copeland C.....1530 W. Taylor
Bowers, Mrs. Garvey B.....421 Morningside
Bowers, Mrs. John A.....1535 W. Jefferson
Bradley, Mrs. Richard V.....3210 Janice Dr.
Brown, Mrs. Earl R., Jr.....1414 Kingston Rd.
Bruegge, Mrs. Theodore J.....2225 S. Wabash
Cattell, Mrs. Lee M.....1235 W. Sycamore
Clarke, Mrs. Elton R.....4320 W. Sycamore
Conley, Mrs. Thomas M.....2811 Dellwood Dr.
Craig, Mrs. R. A.....4105 W. Sycamore Rd.
Craig, Mrs. Reuben.....410 S. Hickory Lane
Cuthbert, Mrs. F. S.....1027 W. Walnut
DeBrota, Mrs. John Jr.....3114 Orleans Ct.
Earl, Mrs. Max M.....2210 S. Wabash
Ericson, Mrs. Homer S.....124 Leafy Lane
Ferry, Mrs. Paul W.....1207 W. Sycamore
Fields, Mrs. Donald L.....3021 Mayfair
Frazier, Mrs. Jack L.....2318 S. Wabash

Fretz, Mrs. Richard C.....4701 Mayfield Dr.
Golper, Mrs. Marvin N.....411 Morningside Dr.
Good, Mrs. Richard P.....227 N. Forest Dr.
Grothouse, Mrs. Carl B.....515 Rainbow Dr.
Guin, Mrs. Jere D.....403 W. Lincoln Rd.
Halfast, Mrs. Richard W.....2505 Katherine Ave.
Harshman, Mrs. James.....4400 Mayfield Dr.
Hutto, Mrs. William H.....West Sycamore Rd.
Jewell, Mrs. G. M.....1318 W. Sycamore
Kremers, Mrs. George A.....2401 S. Wabash
Lehman, Mrs. David P.....3505 Melody Lane
Longshore, Mrs. Robert E.....145 Westmoreland
McClure, Mrs. Warren N.....309 Lody Lane
McIndoo, Mrs. R. E.....820 W. Walnut
Mendelson, Mrs. Stanley M.....2325 S. Wabash
Michael, Mrs. Robert L.....4610 W. Sycamore Rd.
Moore, Mrs. John M.....813 Melody Lane
Morrison, Mrs. W. R.....415 Conradt Ave.
Murray, Mrs. Ernest C.....2200 S. Webster
Paris, Mrs. Durward W.....2417 S. LaFountain
Perkins, Mrs. P. L.....2425 S. Washington
Phares, Mrs. Robert W.....R. R. 1, Box 31A
Prather, Mrs. Philip E.....123 Magnolia Dr.
Radpour, Mrs. Shokri.....4509 Mayfield Dr.
Rudicel, Mrs. Max W.....321 Kingston Rd.
Schwartz, Mrs. F. C.....5015 W. Sycamore Rd.
Shenk, Mrs. Earl M.....306 N. Webster
Sorenson, Mrs. Raymond..4301 Miller Wood Lane
Wachob, Mrs. Tom W., Jr.....806 James Dr.
Wible, Mrs. James H.....2705 W. Jefferson Rd.

Evans, Mrs. Robert W.....Russiaville

HUNTINGTON COUNTY

Huntington

Brubaker, Mrs. Harold S.....721 Flaxmill Rd.
Casey, Mrs. Stanley M.....408 E. Market St.
Clark, Mrs. Joseph H.....R. R. 9
Cope, Mrs. Stanton E.....1022 N. Jefferson St.
Doermann, Mrs. Paul E.....1522 Cherry St.
Erehart, Mrs. Mark G.....Maple Grove Rd.
Eviston, Mrs. J. Boyd.....1362 Poplar St.
Gill, Mrs. D. Richard.....1412 Oak St.
Grayston, Mrs. Wallace S.....303 E. Market St.
James, Mrs. Thomas, Jr.....1044 Poplar St.
Marks, Mrs. Howard H.....1120 N. Jefferson St.
Meiser, Mrs. Robert D.....1738 Cherry St.
Mitman, Mrs. Floyd B.....1470 Poplar St.
Omstead, Mrs. Trevalyn W.....229 Vine St.
Peare, Mrs. Reeve B.....1517 Cherry St.
Van Campen, Mrs. Warren....354 E. Washington
Wagner, Mrs. Richard W.....Old Andrews Rd.
Wheeler, Mrs. Barth E.....418 Etna Ave.

Woods, Mrs. Halden C.....Markle
Cooper, Mrs. B. Trent.....Roanoke
Bennett, Mrs. J. B.....Warren
Ray, Mrs. Carl S.....Box 55, Warren

JACKSON-JENNINGS COUNTIES

Brownstown

Gillespie, Mrs. G. R.....710 Commerce
Scharbrough, Mrs. William.....R. R. 2
Shields, Mrs. Jack.....721 W. Spring

Crothersville

Adair, Mrs. W. K.....208 S. Armstrong
Bard, Mrs. Frank B.....305 E. Howard

North Vernon

Berkshire, Mrs. Shaffer.....110 Long St.
Calli, Mrs. Louis J.....408 S. State
Ellis, Mrs. Forrest D.....130 W. Long St.
Johnson, Mrs. William A.....318 Jennings St.
Thayer, Mrs. Benet W.....214 Jennings St.

Seymour

Baxter, Mrs. Harry..710 West Dr., Sunset Pkwy.
Black, Mrs. J. M...671 Braewick Rd., Sunset Pkwy.
Bobb, Mrs. Kenneth E.....311 Lee Blvd.
Bosch, Mrs. Ralph O..930 South Dr., Sunset Pkwy.
Day, Mrs. Durbin.....515 W. Sixth St.
Graessle, Mrs. H. P...640 East Dr., Sunset Pkwy.
Kamman, Miss Martha.....332 W. Oak St
Martin, Mrs. Guy.....1408 Ewing St.
Ripley, Mrs. John W.....2001 Ewing St.
Shortridge, Mrs. Wilbur.....Mill St.
Templeton, Mrs. Ian.....348 Carter Blvd.
Wiethoff, Mrs. C. A...615 West Dr., Sunset Pkwy.

Knotts, Mrs. Slater.....R. R. 3, Columbus

JASPER COUNTY

Rensselaer

Beaver, Mrs. Raymond E.....111 Thompson St.
Jones, Mrs. Edwin F.....406 Milton
O'Brien, Mrs. Francis E.....530 Park Ave.
Ockerman, Mrs. Kenneth R.....202 Home St.
Schantz, Mrs. Richard.....418 S. Kentucky St.
Williams, Mrs. Paul A.....402 N. Weston St.

JAY COUNTY

Andrews, Mrs. Frank.....R. R. 2, Geneva
Donnally, Mrs. George.....R. R. 1, Geneva

Portland

Cripe, Mrs. William H.....507 W. High St.
Fitzpatrick, Mrs. James S.....405 W. Race St.
Gillum, Mrs. Eugene.....W. Votaw St.
Keeling, Mrs. F. E.....609 W. Race St.
Morrison, Mrs. George G.....R. R. 4
Schenck, Mrs. Ralph.....R. R. 2, W. 7th St.
Spahr, Mrs. Donald E.....615 W. Race St.
Steffy, Mrs. Ralph M.....321 E. Race St.
Vormohr, Mrs. Joseph F.....1011 S. Meridian St.

JOHNSON COUNTY

Franklin

Andrews, Mrs. Hugh K.....R. F. D. 4
Bullers, Mrs. Robert C.....395 S. Home Ave.
Bullington, Mrs. George.....R. F. D. 4
Chappel, Mrs. A. T.....1101 North Dr.
Deppe, Mrs. Charles F.....1215 Park Ave.
Ferrara, Mrs. Joseph F.....1000 E. King St.
Foster, Mrs. R. H. K.....1025 Orchard Lane
Hibbs, Mrs. W. G.....R. F. D. 1
Jones, Mrs. Charles A.....1010 E. Adams Dr.
Mock, Mrs. Harry E.....201 E. Monroe St.
Murphy, Mrs. Harry E.....150 N. Main St.
Portteus, Mrs. Walter L.....R. R. 2
Province, Mrs. Wm. D.....51 N. Water St.
Records, Mrs. Arthur W.....216 E. Jefferson St.
Records, Mrs. John M.....1138 Orchard Lane
Ritteman, Mrs. George.....R. R. 3, Box 19A
Stogsdill, Mrs. W. W.....R. R. 4
Walters, Mrs. Jack L.....1205 E. Jefferson St.
Wesemann, Mrs. Merrill M.....17 Morning Dr.

Greenwood

Brown, Mrs. George E.....404 Beech Park Dr.
Link, Mrs. Charles.....208 S. Fairview
Machledt, Mrs. John.....243 S. Madison Ave.
Ogle, Mrs. Robert.....474 W. Wiley
Sheek, Mrs. Kenneth I.....407 S. Forest Dr.
Snodgrass, Mrs. Robert.....480 Beech Park Dr.
Tiley, Mrs. George.....40 N. Madison
Young, Mrs. Joseph W.....904 Beech Park Dr.

KNOX COUNTY

Vincennes

Anderson, Mrs. John B.....1202 Busseron St.
Anderson, Mrs. Richard M.....Monroe City Rd.
Arbogast, Mrs. Paul B.....1420 Old Orchard Rd.
Barrett, Mrs. Thomas L.....2520 Old Orchard Rd.
Bartlett, Mrs. Donald T.....1315 McDowell Rd.
Beckes, Mrs Ellsworth W.....220 N. Fifth St.
Black, Mrs. Boyd K.....1008 State Road 67-N
Chattin, Mrs. Herbert O.....729 Main St.
Coffel, Mrs. Melvin H.....Simpson Lake
Corsentino, Mrs. Bart E.....110 State Road 67
Curtner, Mrs. Myron L.....216 N. Sixth St.
Edwards, Mrs. Edward T., Jr...Old Bruceville Rd.
Hendrix, Mrs. Charles.....1202 E. Sycamore
Humphreys, Mrs. Joe E.....1602 Weed Lane
McCormick, Mrs. Hubert D.....518 N. Fourth St.
McDowell, Mrs. M. M.....1322 Audubon Rd.
McMahan, Mrs. V. C.....Monroe City Rd.
Nichols, Mrs. Robert J.....1906 John R. Rd.
Parmenter, Mrs. Harry B.....205 Elm Lane
Reilly, Mrs. James F.....401 Buntin St.
Saul, Mrs. F. William.....816 Buntin St.
Shaffer, Mrs. Kenneth L.....2600 Ridge Rd.
Shanklin, Mrs. Jack L.....1545 Barnett Lane
Smith, Mrs. S. Joseph.....504 N. Fourth St.
Smith, Mrs. Ralph O.....Old Bruceville Rd.
Spencer, Mrs. Frederic.....902 Perry St.
Stein, Mrs. Richard H.....1209 Old Orchard Rd.
Stewart, Mrs. Frank W.....Hillcrest Rd.
Tolbert, Mrs. Robert D.....9 S. 20th St.
Vaughn, Mrs. Walter R.....2018 Prospect Ave.
Welch, Mrs. Norbert M.....Monroe City Rd.

KOSCIUSKO COUNTY

Gill, Mrs. D. D.....R. R. 2, Leesburg
Urschel, Mrs. Dan L.....Mentone
Wilson, Mrs. Wymond B...P. O. Box 421, Mentone
Hursey, Mrs. Virgil G.....Milford
Pierson, Mrs. Pearl H.....R. R. 1, Silver Lake
Baum, Mrs. John R.....307 7th St., Winona Lake

Warsaw

Arford, Mrs. John E.....1319 E. Center St.
Brooks, Mrs. Leonard C.....722 E. Center St.
Cron, Mrs. William J.....1548 Country Club Dr.
Hashemi, Mrs. Hossein.....1306 Ranch Rd.
Haymond, Mrs. George M...945 Country Club Dr.
Hillery, Mrs. John L.....823 E. Center
Hogle, Mrs. Frank.....R. F. D. 2
Keough, Mrs. Thomas F.....320 N. Lake St.
Laird, Mrs. L. A.....1816 E. Sheridan
Murphy, Mrs. Samuel C.....216 South High St.
Reed, Mrs. E. A.....1219 E. Main St.
Richer, Mrs. Orville.....914 E. Main St.
Schlemmer, Mrs. George H.....528 N. Lake St.
Shrader, Mrs. Carl.....Spring Hill Acres
Thomas, Mrs. E. Winton.....711 E. Main St.

LAKE COUNTY

Cedar Lake

Miller, Mrs. Donald C.....P. O. Box 297
Misch, Mrs. William A.....R. R. 4, Box 58

Crown Point

Gutierrez, Mrs. P. E.....729 Williams Dr.
Horst, Mrs. William.....468 Lake St.

East Chicago

Campagna, Mrs. E. A.....4320 Ivy St.
Ernst, Mrs. H. C.....4219 Baring Ave.
Fleischer, Mrs. J. C.....4135 Ivy St.
Gustaitis, Mrs. John W.....4318 Parrish Ave.
Niblick, Mrs. James S.....4115 Fir St.
Perdomo, Mrs. Octavio.....4217 Euclid
Romero, Mrs. Plinio.....2103 Franklin St.
Serna, Mrs. Jesus A.....4316 Parrish Ave.
Shapiro, Mrs. Joseph.....4214 Parrish Ave.

East Gary

Markle, Mrs. Joseph G.....3143 Ripley
Mather, Mrs. J. Winford.....2367 Vigo St.
Penn, Mrs. R. A.....2334 Vigo St.

Gary

Almquist, Mrs. C. O.....550 Lincoln St.
Amico, Mrs. Pasquale.....2119 W. 50th Pl.
Bills, Mrs. R. J.....410 Roosevelt St.
Bills, Mrs. Robert N.....534 Lincoln St.
Brady, Mrs. Samuel J.....451 Garfield St.
Brincko, Mrs. John.....3537 Harrison St.
Cahue, Mrs. A. R.....634 Taft St.
Carberry, Mrs. George.....591 Johnson St.
Carbone, Mrs. Joseph A.....526 Johnson St.
Dasaro, Mrs. George.....7716 Juniper
English, Mrs. Hubert M.....575 Taft St.
Fadell, Mrs. Matthew.....701 W. 55th Ave.
Gallinatti, Mrs. J. J.....7413 Locust St.
Glover, Mrs. W. J.....3540 Tyler St.
Goldberg, Mrs. Harold B.....825 W. 35th Ave.
Goldstone, Mrs. Adolph.....3578 Buchanan
Goldstone, Mrs. Joseph.....339 W. 35th Ave.
Goldstone, Mrs. Robert.....717 Newton St.
Gregoline, Mrs. A. F.....700 Arthur
Gregoline, Mrs. Eugene.....330 Taney St.
Hadey, Mrs. James H.....505 Taft St.
Halikiopoulos, Mrs. H. J.....435 W. 55th Ave.
Hodurski, Mrs. Zigfield.....4420 Adams
Jahns, Mrs. A. A.....655 Roosevelt St.
Kobrin, Mrs. Meyer.....2300 W. 6th Ave.
Kolettis, Mrs. J. G.....847 W. 35th St.
Kopcha, Mrs. Joseph E.....650 Pierce St.
Lazo, Mrs. Vicente.....707 Harrison St.
Lorenty, Mrs. Thaddeus.....3654 Madison
Lytwakiwsky, Mrs. Anatol.....8700 Forest Ave.
Manalo, Mrs. F. S.....538 Lincoln St.
May, Mrs. R. Milton.....667 Van Buren St.
Milos, Mrs. Robert.....725 Filmore St.
Morris, Mrs. Hyman.....2401 W. Sixth Ave.
Moswin, Mrs. Jack A.....701 Arthur St.
Nelson, Mrs. Walfred A.....1050 Warren St.
Oberlander, Mrs. Seymour....400 S. Grand Blvd., Apt. 311
Olson, Mrs. Leslie.....716 Grant St.
Ornelas, Mrs. Joseph P.....6339 Oakwood Lane
Pappas, Mrs. Edward T.....569 Pierce St.
Platis, Mrs. James.....4645 Pierce St.
Poracky, Mrs. Bernard F.....5598 Van Buren St.
Radigan, Mrs. Leo R.....6624 Birch St.
Robinson, Mrs. Walter K...500 N. Montgomery St.
Rubin, Mrs. Simon S.....2131 W. Fifth Ave.
Ryan, Mrs. H. J.....630 McKinley
Sala, Mrs. Joseph.....2333 W. 55th Ave.
Schulz, Mrs. Kurt J.....5814 Roosevelt St.
Scully, Mrs. John T.....715 Johnson St.
Senese, Mrs. Thomas J.....581 Johnson St.
Serna, Mrs. Carlos.....625 Roosevelt St.
Shevick, Mrs. Alexander.....733 Fillmore St.
Spellman, Mrs. Frank W.....6941 Ironwood Ave.
Stimson, Mrs. Harry R.....4338 Jefferson St.
Thomas, Mrs. Daniel D.....2001 W. 7th Ave.
Valencia, Mrs. M. M.....7700 Hemlock
Yocum, Mrs. Paul, Sr.....6999 Hemlock
Young, Mrs. George M.....4580 Washington St.
Zucker, Mrs. Edward.....7009 E. First St.

Griffith

Carpenter, Mrs. B. F.....808 Glenwood
Lundeberg, Mrs. Ralph A.....1211 N. Harvey
Riordan, Mrs. John.....318 W. Glen Park Ave.
Siekierski, Mrs. J. M.....445 N. Broad Street

Hammond

Allegretti, Mrs. Michael L.....6237 Forest Ave.
Bacevich, Mrs. A. J.....6939 Olcott Ave.
Barron, Mrs. Elmer A.....6635 Kansas
Beconovich, Mrs. Robert.....6540 Forest Ave.
Bonaventura, Mrs. Angelo P...7112 Woodmar Ave.
Cotter, Mrs. Edward R. 7225 Knickerbocker Pkwy.
Dosado, Mrs. E. B.....7530 Magoun Ave.
Eggers, Mrs. Ernest.....635 165th St.
Eggers, Mrs. H. W.....6542 Hohman Ave.
Egnatz, Mrs. Nicholas.....820 Highland St.
Elledge, Mrs. Ray.....6415 Forest Ave.
Fedor, Mrs. T. A.....6738 Hohman Ave.
Fischer, Mrs. Burnell.....49 Indi-Illi Park
Gevirtz, Mrs. Milton B.....7142 Hohman Ave.
Hack, Mrs. Edmund C.....7147 Olcott St.
Hickman, Mrs. A. Lee, Jr.....7412 Knickerbocker
Howard, Mrs. Wm. H.....41 Glendale Pk.
Husted, Mrs. Robert G.....7248 Forest Ave.
Kmak, Mrs. Chester J.....6737 Magoun Ave.
Komoroske, Mrs. John E.....35 Highland Ave.
Koransky, Mrs. David S.....7048 Forest Ave.
Kretsch, Mrs. Russell W.....7214 Hohman Ave.
Marks, Mrs. Ora L.....7111 Olcott Ave.
Mason, Mrs. Richard L.....132 Rimbach Ave.
Modjeski, Mrs. Joseph R.
7327 Knickerbocker Pkwy.
Neal, Mrs. L. W.....7301 Forest Ave.
Panares, Mrs. Solomon V.....4 172nd Pl.
Peck, Mrs. Edward A.....6422 Moraine Ave.
Pilot, Mrs. Jean.....7137 Knickerbocker Pkwy.
Polite, Mrs. Nicholas L.....7320 California
Premuda, Mrs. Franklin F....7042 Woodmar Ave.
Ramker, Mrs. Daniel T.....7129 Arizona Ave.
Remich, Mrs. Antone C.....6412 Moraine Ave.
Rendel, Mrs. Donald T.....18—172nd Pl.
Repay, Mrs. W. A.....7505 Knickerbocker Pkwy.
Rhind, Mrs. A. W.....7126 Forest Ave.
Rosevear, Mrs. Henry J.....6531 Forest Ave.
Row, Mrs. Perrie Q.....6712 Hohman Ave.
Rubright, Mrs. Robert L.....7258 Forest Ave.
Rudolph, Mrs. F. G.....6607 Forest Ave.
Santare, Mrs. Vincent J.....6508 Forest Ave.
Schlesinger, Mrs. Daniel J.....6633 Forest Ave.
Stecy, Mrs. Peter.....1543 Warwick
Stern, Mrs. S. Lewis.....226 Oakwood
Teegarden, Mrs. Joseph A., Jr.
7204 Woodman Ave.
Thegze, Mrs. George A.....7435 Olcott Ave.
Trachtenberg, Mrs. Lee.....7226 Tilly Dr.
Wong, Mrs. Samuel N.....632—169th St.

Highland

Beilke, Mrs. C. A.....8723 Parkway Dr.
Dumanian, Mrs. Ara V.....8949 Lawndale
Larrabee, Mrs. James.....2214 Oakdale
Tilka, Mrs. Ed. C.....8740 Parkway Dr.
White, Mrs. G. H., Jr.....8754 Parkway Dr.

Hobart

Bernard, Mrs. Marvin R.....6430 Grand Blvd.
Carter, Mrs. John.....400 S. Wabash
Doneff, Mrs. Ronald.....R. R. 1, U.S. 6
Faulkner, Mrs. Donald.....295 S. Wisconsin
Goodwin, Mrs. Thomas.....3408 Randolph Pl.
Kellar, Mrs. Philip E.....1331 Lincoln St.
Krsek, Mrs. Archie.....1216 State St.
Pike, Mrs. Warren, Jr.....Ainsworth Rd.
Reed, Mrs. John.....445 Kelley

Munster

Alt, Mrs. Edward M. Jr.....8804 Baring
Angel, Mrs. Virgil E.....8638 Baring
Arbeiter, Mrs. Herbert I.....119 Beverly Place
Arrowsmith, Mrs. James L.....8138 Forest Ave.
Benchik, Mrs. Frank A.....8326 Hawthorne Dr.
Bombar, Mrs. Leslie E.....8318 Oakwood
Boys, Mrs. F. F.....8517 Crestwood Ave.
Chael, Mrs. Tom C.....225 Belmont Place
Costello, Mrs. Albert J.....1404 Fisher
Espino, Mrs. J. C.....8523 Forest Ave.
Gardiner, Mrs. H. Glen.....1406 McArthur
Griffith, Mrs. Thomas E.....1208 Fisher
Kenney, Mrs. Francis.....8131 Forest Ave.
Kuhn, Mrs. Arthur J.....1535 35th St.
Lanman, Mrs. John U.....1321 Elliott Dr.
Lautz, Mrs. Herbert A.....7943 Forest Ave.
Long, Mrs. Keith J.....1327 Ridgeway
Madlang, Mrs. R. M.....7750 Hohman Ave.
Marks, Mrs. Salvo P.....8320 Parkview Ave.
Maroc, Mrs. James.....231 Hollywood
Mason, Mrs. John C.....7939 Jackson
McLean, Mrs. James S.....1836 Ridge Rd.
Modjeski, Mrs. Raymond J.....1448 Elliott Dr.
Montes, Mrs. H.....7915 Hohman Ave.
Nierman, Mrs. Murray.....1544 Fischer
Paul, Mrs. Eudell G.....7905 Hohman Ave.
Rasch, Mrs. George C.....1519 35th St.
Rosenthal, Mrs. Carl.....8330 Schrieber Dr.
Schlesinger, Mrs. Jacob.....7648 Hohman Ave.
Shapiro, Mrs. Seymour W.....1517 Melbrook
Smith, Mrs. Jerald.....239 Fairbanks
Snyder, Mrs. Jerome.....1210 Park Drive
Sroka, Mrs. Stanley J.....7540 Forest Ave.
Stasick, Mrs. Murray 8611 Baring Ave.
Stevens, Mrs. Edwin W.....8627 Beech
Sweany, Mrs. Stanford.....8030 Jackson
Teplinsky, Mrs. L. L.....1528 Twelve Oaks Dr.
Westhaysen, Mrs. Peter V.....127 Beverly Pl.
Wooden, Mrs. Thomas F.....8351 Crestwood

Whiting

Greisen, Mrs. J. C.....1709 Stanton Ave.
Weinberg, Mrs. B. A.....2022 Lake Ave.

Ambrozaitis, Mrs. Kazys G.
Box 404, Portage
Armalavage, Mrs. Leon J.....R. R. 4, Valparaiso

Angeles, Mrs. Uldarico.....5848 N. Kenmore,
Chicago 40, Ill.
Dimitroff, Mrs. Lambro
1021 Forest Hills, Calumet City, Ill.
Feinsot, Mrs. Irving
17 Forestdale Park, Calumet City, Ill.
Lipschutz, Mrs. Harold
6723 Oglesby Ave., Chicago 49, Ill.
Mansueto, Mrs. Mario D.
4 Forestdale, Calumet City, Ill.
Sroka, Mrs. A. G.....17216 Wentworth Ave.,
Lansing, Ill.
Stasick, Mrs. Murray.228 W. Warren, Lansing, Ill.
Portney, Mrs. Fred.....18745 Royal Rd.,
Homewood, Ill.
Tyrrell, Mrs. Joseph J.
16041 S. Ellis, South Holland, Ill.

LaPORTE COUNTY

LaPorte

Backer, Mrs. George P.....1533 Michigan Ave.
Carpentier, Mrs. James R.....110 W. 15th St.
Carter, Mrs. Fred S.....208 Forest Dr.
Cartwright, Mrs. J. D.....1003 Indiana Ave.
Datzman, Mrs. Basil J.....1421 Indiana Ave.
Deren, Mrs. Matthew.....110 Lane St.
Durham, Mrs. Lowell J.....1808 Indiana Ave.
Erwin, Mrs. Winford R.....4 Ballywood Drive
Feinn, Mrs. Harry S.....1534 Michigan Ave.
Kelsey, Mrs. Robert M., Jr.....1305 Indiana Ave.
Kelsey, Mrs. Robert M., Sr.....702 Maple Ave.
Kepler, Mrs. Robert W.....1529 Michigan Ave.
Larson, Mrs. Goyt, O.....Ridgefield Addition
Mead, Mrs. Frank E.....344 Grayson Rd.
Mladick, Mrs. Edward A.....314 Holton Rd.
Moore, Mrs. William G.....2203 Southwest Rd.
Moosey, Mrs. Louis.....2007 Michigan Ave
Mueller, Mrs. Edwin C.....117 Evergreen Dr.

Muhleman, Mrs. Charles E.....Greenacres
Oak, Mrs. David D.....1104 Andrew Ave.
Philbrook, Mrs. Seth S.....212 Forest Dr.
Richter, Mrs. John C.....2020 Beechwood Ct.
Sanchez, Mrs. Jose.....2424 Monroe St.
Scott, Mrs. John S.....508 Lake Shore Dr.
Sirugo, Mrs. Aldo C.....202 Forest Dr.
Sprecher, Mrs. James J. J.....1308 Michigan Ave.
Von Asch, Mrs. George.....2030 Michigan Ave.

Carter, Mrs. William D.....Walkerton
Rohrer, Mrs. Bryce B.....Walkerton
Benz, Mrs. Owen F.....P. O. Box 163, Wanatah
Dieter, Mrs. William J.
Beatty Memorial Hospital, Westville

LAWRENCE COUNTY

Bedford

Allen, Mrs. L. Howard.....1318 14th St.
Austin, Mrs. Richard P.....1315 15th St.
Campbell, Mrs. William T.....348 Eastwood Dr.
Duncan, Mrs. Raymond E.....407 Northwood Dr.
Dusard, Mrs. Joseph C.....1107 N. St.
Edmonds, Mrs. Kendrick T.....1303 15th St.
Emery, Mrs. Charles B.....Brook Knoll
Fountaine, Mrs. Thomas J.....1620 18th St.
Hammel, Mrs. Howard T.....1822 15th St.
Hawkins, Mrs. Richard D.....1308 15th St.
Kasting, Mrs. Gerald E.....Parkview Addition
Kerr, Mrs. Donald M.....1415 20th St.
Morrow, Mrs. Robert J.....Brook Knoll
Noe, Mrs. William R.....118 Woodhill Dr.
Reuter, Mrs. John W.....405 Northwood Dr.
Scherschel, Mrs. John P.....1713 H St.
Waldo, Mrs. Guy H., Jr.....308 Eastwood Dr.
Wohlfeld, Mrs. J. B.....1224 15th St.
Woolery, Mrs. Richard R.....2020 Denson Ave.

Benham, Mrs. Lawrence E.....R. R. 2, Springville

MADISON COUNTY

Gahimer, Mrs. Joseph E.....R. R. 2, Alexandria
Leroy, Mrs. A. G.....Alexandria
Owens, Mrs. T. F...302 Lincoln Ave., Alexandria

Anderson

Aagesen, Mrs. W. J.....3 Wind Ridge Rd.
Armington, Mrs. Charles L.....823 W. Seventh St.
Armington, Mrs. John C.....206 W. 14th St.
Austin, Mrs. Charles E.....1612 Westwood Dr.
Baughn, Mrs. William L.....1517 Winding Way
Beeler, Mrs. Frank K.....20 Overlook Dr.
Bixler, Mrs. Donald P.....1515 Green Way Dr.
Blassaras, Mrs. Crist A.....916 Dresser Dr.
Bowers, Mrs. Richard C.....1110 Greenway Dr.
Bridges, Mrs. Alvin L.....R. R. 2, Box 296 A
Brown, Mrs. James M.....909 Forest Dr.
Buckles, Mrs. David L.....44 Knoll Rd.
Bush, Mrs. Edw. R.....31 Urban Rd.
Castetter, Mrs. Gregory K...711 Alexandria Pike
Conrad, Mrs. Ernest M.....2124 Meridian St.
Doenges, Mrs. James L.....1601 Van Buskirk Rd.
Donaldson, Mrs. Frank C.....2 Wind Ridge Rd.
Drake, Mrs. James R.....2029 W. 12th St.
Drake, Mrs. John C.....920 N. Madison Ave.
Drennen, Mrs. Robert V...1230 E. Chesterfield Dr.
Dulin, Mrs. Basil B.....1120 Maryland Drive
Ellis, Mrs. Seth W.....1105 Green Way Dr.
Elsten, Mrs. Wayne A.
1333 Maryland Dr., Forest Manor
Erehart, Mrs. Archie D.....2219 W. Ninth St.
Faust, Mrs. Howard Jr.....1321 W. Eighth St.
Ferguson, Mrs. Donald H.....3430 Redwood Rd.
Fischer, Mrs. Warren E.....1410 Van Buskirk Rd.
Gante, Mrs. Henry W.....2005 Nichol Ave.
Harvey, Mrs. E. C. Jr.....3617 Manor Rd.
Jones, Mrs. Albert T.....3316 Cherry Rd.
Jones, Mrs. David G.....R. R. 5, Box 187
Kelly, Mrs. Wendell C.....23 Colony Rd.
Kiely, Mrs. John T.....1011 Raible
King, Mrs. Joseph W.....311 W. Eighth St.
Kopp, Mrs. William R.....2410 W. 12th St.
Lamey, Mrs. Paul T.....1740 W. 10th St.
Land, Mrs. Richard.....509 Pershing Dr.
Larmore, Mrs. Joseph L.....1301 Winding Way
Litzenberger, Mrs. Sam W.....823 Forrest Dr.
Long, Mrs. Paul L.....828 Dresser Dr.
Metcalf, Mrs. George B.....830 W. Eighth St.
Moneyhun, Mrs. James E.....1815 Ivy Dr.
Neale, Mrs. Alfred E.....725 Forest Dr.
Nesbit, Mrs. Leonard L.....60 River Forest
Patterson, Mrs. William K.....3 South Park Dr.
Polhemus, Mrs. Warren C.....1300 W. 11th St.
Rosenbaum, Mrs. Lloyd E.....804 Dresser Dr.
Ross, Mrs. Guy E.....1124 N. Madison Ave.
Sharp, Mrs. William L.....725 North Shore Blvd.
Sheldon, Mrs. Suel A.....2812 Greenbriar Rd.
Stamper, Mrs. Jos. H.....619 State Road 67 West
Stamper, Mrs. Robert J.....R. R. 6, Box 78A
Starks, Mrs. William O.....2536 W. 12th St.
Stinson, Mrs. William M.....17 River Forest
Swan, Mrs. Richard C.....707 Forrest Dr.
Wagoner, Mrs. John R.....3522 Hawthorne Rd.
Webb, Mrs. Harry D.....1308 Maryland Dr.
Weiss, Mrs. Louis L.....1225 N. Madison Ave.
Wilder, Mrs. G. B.....338 W. 8th St.
Williams, Mrs. Francis M.....1012 Park Rd.
Williams, Mrs. Robert H...715 North Shore Blvd.
Wilkinson, Mrs. Roger L.....1525 Winding Way
Wishard, Mrs. Fred B.....2604 E. 4th St.
Woodbury, Mrs. C. R.....235 Park Road

Kepner, Mrs. R. S.....Chesterfield
Bishop, Mrs. Harry A.....Frankton
Williams, Mrs. Robert D.....Markleville
Begley, Mrs. Robert W...112 W. High, Pendleton
Heckaman, Mrs. Ed.....Box 28, Pendleton
McLaughlin, Mrs. C. B.....R. R. 2, Pendleton
Van Ness, Mrs. William.216 S. Main, Summitville

MARION COUNTY

Dill, Mrs. Charles W.....4111 S. Sherman Dr., Beech Grove
Ramage, Mrs. Walter F.....244 S. First St., Beech Grove
Link, Mrs. Goethe.....Box 84, Brooklyn
Cuthbert, Mrs. Marvin P..R. R. 2, Box 386, Carmel
Nolin, Mrs. Richard T..R. R. 2, Box 323D, Carmel
Schaffer, Mrs. Edward V.
R. R. 1, Box 614A, Carmel
Myers, Mrs. Roy V.
7710 Beta Circle, W. Palm Beach, Fla.
Onyett, Mrs. Harold R..R. R. 3, Box 32, Greenwood

Indianapolis

A

Albertson, Mrs. Frank P...5031 Rockville Rd. (24)
Aldrich, Mrs. Harry D.....5805 Sherman Dr. (20)
Alig, Mrs. Vincent B.....6453 Green Leaves (20)
Allen, Mrs. Robert K.....737 Sherwood Dr. (40)
Alvis, Mrs. Edmond O.....474 W. 92nd St. (60)
Anshutz, Mrs. William M..6340 Braemore Rd. (20)
Antreasian, Mrs. Berj.....5465 Mark Lane (26)
Appel, Mrs. Richard H.....122 E. 61st St. (20)
Arbogast, Mrs. John L. 3933 Washington Blvd. (5)
Arbuckle, Mrs. William E.
5326 E. St. Joseph St. (19)
Armer, Mrs. Robert M...4208 Cold Spring Rd. (8)
Armstead, Mrs. John W..432 W. Hampton Dr. (8)
Avery, Mrs. George O...5321 N. Kessler Blvd. (8)

B

Bachmann, Mrs. Arnold J.....1615 Oles Drive (8)
Bakemeier, Mrs. Otto H..5535 E. St. Clair St. (19)
Bakemeier, Mrs. Robert E.
1210 N. Butler Ave. (19)
Balch, Mrs. James E.....4444 College Ave. (5)
Balch, Mrs. James, Jr.....5826 Sylvan Dr. (8)
Ball, Mrs. Joseph E.....6612 E. Ninth St. (19)
Baptisti, Mrs. Arthur, Jr.
4401 N. Meridian St. (8)
Bastnagel, Mrs. William F.
5430 Washington Blvd. (20)
Batman, Mrs. Gordon W.
6906 N. Delaware St. (20)
Battersby, Mrs. J. Stanley..6001 Sunset Lane (8)
Bauer, Mrs. Thomas....7685 Clarendon Rd. (60)
Baumeister, Mrs. Herbert E.....4421 E. 75th (20)
Beamer, Mrs. Parker R...4620 Boulevard Pl. (8)
Beasley, Mrs. Thos. J.....715 E. 70th Place (20)
Beaver, Mrs. Howard W.
303 E. Edgewood Ave. (27)
Beck, Mrs. Evart M.....6445 N. Olney St. (20)
Becker, Mrs. Harry G...5641 Haverford Ave. (20)
Beeler, Mrs. John W.....7974 N. Illinois St. (60)
Beeler, Mrs. Raymond C.....3777 N. Meridian (5)
Belt, Mrs. James H.....8271 Forest Lane (40)
Benedict, Mrs. Paul F.....2550 Blue Grass Dr. (8)
Bennett, Mrs. Ivan F.....R. R. 18, Box 285 (24)
Berman, Mrs. J. K.....2810 W. 38th St. (8)
Bibler, Mrs. Lester D.
4360 N. Pennsylvania St. (5)
Blackwell, Mrs. Donald S. 2121 Allison Ave. (24)
Blake, Mrs. Albert L...6471 Knyghton Rd. (20)
Blatt, Mrs. A. Ebner....5330 N. Illinois St. (8)
Boling, Mrs. Fred F.....5408 W. 36th St. (24)
Boling, Mrs. Grover C., Jr.
6205 Bramshaw Rd. (20)
Bomalaski, Mrs. Donald....6491 N. Oxford (20)
Bowman, Mrs. George W.
5634 Carrollton Ave. (20)
Boyer, Mrs. Floyd A.....136 S. Wittfield St. (19)
Brady, Mrs. Thomas A., Jr.
225 Wellington Rd. (20)
Brayton, Mrs. John R.
3128 E. Fall Creek Blvd., N. Dr. (5)
Brayton, Mrs. Lee.....5540 N. Illinois St. (8)
Brillhart, Mrs. James R...5731 Kilmer Lane (20)
Brodie, Mrs. Donald W.....R. R. 13, Box 397 (26)
Brown, Mrs. Archie E.
4145 Melbourne Rd., W. Dr. (8)
Brown, Mrs. David E.....R. R. 16, Box 93 (78)
Brown, Mrs. DeWitt W., Jr.
4363 Cold Springs Rd. (8)
Brown, Mrs. Gordon T. 3325 Breckenridge Dr. (8)
Brown, Mrs. Wendell E.....3750 N. Gale St. (18)
Browning, Mrs. James S.
7961 Windcombe Blvd. (40)
Bruce, Mrs. Reginald A...5752 Grandiose Dr. (8)
Brueckmann, Mrs. F. Robert 2356 N. Kenyon (19)
Burdette, Mrs. Harold.....6310 Glencoe Dr. (20)
Butler, Mrs. Robert M...4849 N. Ritter Ave. (26)

C

Cahn, Mrs. Hugo....5535 N. Pennsylvania St. (20)
Call, Mrs. Herbert F.....710 E. 57th St. (20)
Campbell, Mrs. H. E., Jr.....5739 Haverford (20)
Campbell, Mrs. Robert L..5726 Sherman Ave. (20)
Carson, Mrs. E. Wayne..7177 N. Meridian St. (20)
Carter, Mrs. Oren E.....5461 Kenwood Ave. (8)
Chattin, Mrs. William R..4825 Cavendish Rd. (20)
Chernish, Mrs. Stanley M...4403 Radnor Rd. (26)
Christie, Mrs. Marvin C.
3340 E. Loretta Drive (27)
Clark, Mrs. Geo. A.....620 Forest Blvd. (40)
Clark, Mrs. Lawson J.
2425 E. Kessler Blvd., E. Dr. (20)
Coggeshall, Mrs. Warren E.
6305 Bramshaw Rd. (20)
Cohn, Mrs. Frank....1120 Southview Dr. (27)
Conway, Mrs. Glenn.....2235 E. Garfield Dr. (3)
Cortese, Mrs. James V.....6302 Minlo Dr. (27)
Cortese, Mrs. Thomas A.....3240 Brill Rd. (27)
Costin, Mrs. Robert L..8028 Morningside Dr. (40)
Countryman, Mrs. Frank 5633 Central Ave. (20)
Cox, Mrs. C. E.....1950 Westlane Rd. (60)
Cross, Mrs. David G.....3001 Redfern Dr. (27)
Culbertson, Mrs. Clyde G.....6060 Park Ave. (20)
Currie, Mrs. Robert W.....512 E. 57th St. (20)
Curry, Mrs. R. Louis.....7250 N. Chester (40)

D

Daley, Mrs. Edward H.
5118 East Dickson Road (26)
Dallas, Mrs. F. R.....7935 E. Michigan (19)
Daly, Mrs. Joseph M.....5969 Singleton Ave. (27)
Davidson, Mrs. Dale A...3025 N. Meridian St. (8)
Davidson, Mrs. N. Cort....2811 W. 96th St. (68)
Davis, Mrs. F. Sterling, Jr.
6019 Williamsburg Court (26)
Davis, Mrs. Sam J.....4545 Broadway (5)
Dearmin, Mrs. Robert M.....3060 N. Meridian St., Apt. 501 (8)
DeArmond, Mrs. Albert M.
5401 N. Delaware St. (20)
Deever, Mrs. John W.....6801 S. East St. (27)
Denny, Mrs. James W.
6633 Spring Brook, N. Dr. (19)
Donato, Mrs. Albert M...5915 Lawrence Dr. (26)
Doran, Mrs. J. Hal.....3705 N. Denny St. (18)
Doughty, Mrs. Samuel R., Jr.
5258 Channing Circle (26)
Douglas, Mrs. William T.....40 N. Ritter St. (19)
Drew, Mrs. Arthur L.
4349 Washington Blvd. (5)
Dryden, Mrs. Gale E...5835 N. Tacoma Ave. (20)
Dugan, Mrs. William M.
5747 Rolling Ridge Rd. (20)
Dupes, Mrs. Lowell E.....5851 White Oak Ct. (20)
Dupler, Mrs. Lee F.....4310 Arcadia St. (22)
Dyar, Mrs. Edwin W., Jr.
5910 Washington Blvd. (20)
Dyke, Mrs. Richard W.....542 W. 83rd (60)

E

Eastman, Mrs. Joseph Rilus 220 W. 64th St. (8)
Eaton, Mrs. Edwin R...5750 Allisonville Rd. (20)
Eaton, Mrs. Lyman D...R. R. 19, Box 487Y (80)
Ebert, Mrs. J. Wayne....1125 Southview Dr. (27)
Egbert, Mrs. Herbert L.....419 W. 63rd St. (8)
Eicher, Mrs. Palmer O. 4401 Washington Blvd. (5)
Eldridge, Mrs. Gail E.....5746 Central Ave. (20)
Elkins, Mrs. James P.....2045 Lick Creek Dr. (3)
Ellis, Mrs. Bert E.....3910 E. 57th St. (20)
Ellis, Mrs. William N.....4908 E. 46th Street (26)
Emhardt, Mrs. John T.....3305 Brill Rd. (27)
Ensminger, Mrs. Leonard A.
1321 N. Meridian St. (2)
Evans, Mrs. Paul V.....7415 Dean Rd. (40)
Everly, Mrs. Ralph V.....1105 E. 58th St. (20)

F

Fausset, Mrs. C. Basil..7757 N. Meridian St. (60)
Ferry, Mrs. Francis A...935 E. Southern Ave. (3)
Finneran, Mrs. Joseph C.....1250 E. 80th St. (40)
Fischer, Mrs. A. Alan....3230 W. 39th Place (8)
Flanagan, Mrs. Paul M.....5842 N. LaSalle (20)
Flanders, Mrs. Robert, Jr.
7232 Sylvan Ridge Rd. (40)
Flanigan, Mrs. Meredith B. 3305 Rutledge Dr. (8)
Flora, Mrs. Joseph O.....5604 Rockville Rd. (24)
Folkening, Mrs. Norval C.....5501 Camden (27)
Forbes, Mrs. Robert S.
4110 Crooked Creek Overlook (8)
Fortuna, Mrs. Frank.....2535 E. Banta Rd. (27)
Foster, Mrs. Lee N., Jr...3824 Ashbourne Ln. (18)
Fouts, Mrs. Paul J.....8393 N. Illinois St. (60)
Franklin, Mrs. William L.....33 E. 37th St.

Freed, Mrs. Carl A.....4334 Springwood Trail (8)
Freeman, Mrs. Leslie W...5601 E. St. Clair (26)
Freeman, Mrs. Max E...4802 Thornleigh Dr. (26)
French, Mrs. Richard N., Jr.
5407 N. Illinois St. (8)
Fry, Mrs. Robert D.....5717 Broadway (20)
Funkhouser, Mrs. A. G.....215 E. 36th (5)

G

Gabovitch, Mrs. Edward R. 595 Holiday Lane (60)
Gaddy, Mrs. E. T.....4580 Lincoln Rd. (8)
Gaddy, Mrs. Nelson D.....2551 Blue Grass Ct. (8)
Galloway, Mrs. John A.....4835 N. Dearborn (5)
Gambill, Mrs. J. R.....4651 Cherry Lane (8)
Garber, Mrs. J. Neill
7036 N. Pennsylvania St. (20)
Garceau, Mrs. George J.
5539 N. Pennsylvania St. (20)
Gardiner, Mrs. Sprague H...330 W. 62nd St. (8)
Gardner, Mrs. Austin
7701 N. Pennsylvania St. (40)
Gardner, Mrs. Buckman.....22 E. 52nd St. (20)
Garner, Mrs. W. Stanley.4021 Cranbrook Dr. (40)
Garrett, Mrs. Robert A...95 Wellington Rd. (8)
Gastineau, Mrs. Frank M.
4444 Kessler Blvd., E. Dr. (20)
Geider, Mrs. Roy A.
5816 Pleasant Run Pkwy., N. Dr. (19)
Gick, Mrs. Herman H.....451 Eastern Ave. (1)
Gifford, Mrs. Fred E...5125 N. Meridian St. (8)
Gillespie, Mrs. Charles F..4530 Berkshire Rd. (18)
Gillespie, Mrs. Jacob E.....4426 Broadway (5)
Ginsberg, Mrs. S. T.....7222 Stevens Lane (60)
Goldman, Mrs. Samuel....428 Woodmere Dr. (20)
Gooding, Mrs. Richard A.....2850 W. 52nd St.
Gormley, Mrs. Joseph J.
4560 Crooked Creek Ridge Dr. (8)
Gosman, Mrs. James H.
4491 Washington Blvd. (5)
Graham, Mrs. John D.....6401 Osborn Dr. (26)
Grayson, Mrs. Ted L. 925 Forest Blvd. N. Dr. (40)
Greene, Mrs. Morgan E.
2014 Winchester Dr. (27)
Greist, Mrs. John H...4343 Washington Blvd. (5)
Griffin, Mrs. Leslie.....3203 W. 57th St. (8)
Grissell, Mrs. Ted L. 5211 Brendon Ridge Rd. (26)
Gustafson, Mrs. Gerald S.
5768 N. Pennsylvania St. (20)

H

Habegger, Mrs. E. Dale....3120 W. 51st St. (8)
Hadley, Mrs. David.5601 N. Pennsylvania St. (20)
Haggard, Mrs. Edmund B.
5914 N. Emerson Ave. (20)
Hall, Mrs. Frank M.
8633 N. Pennsylvania St. (40)
Hall, Mrs. Jack H.....6241 E. 43rd St. (26)
Hamilton, Mrs. Howard B.
3425 Green Hills Overlook (22)
Hampshire, Mrs. Donald R.
7979 Morningside Dr. (40)
Hann, Mrs. E. Carl ...5218 Laurel Hall Dr. (26)
Harcourt, Mrs. Allan K.
5418 Allisonville Rd. (20)
Harding, Mrs. M. Richard 4220 Devon Court (18)
Harger, Mrs. Robert W...46 West 52nd Street (8)
Harold, Mrs. Norris E...3545 N. Denny St. (18)
Harvey, Mrs. Verne K., Sr.
2601 Cold Spring Rd. (22)
Haslinger, Mrs. Clarence J.
5236 Boulevard Pl. (8)
Hatfield, Mrs. Jack J. 5538 N. Keystone Ave. (20)
Hatfield, Mrs. Nicholas W...5851 E. 54th Pl. (26)
Hawk, Mrs. James H.....400 E. 43rd St. (5)
Haymond, Mrs. Joseph L.
2745 Crescent Hill Lane (8)
Hays, Mrs. Everett L.....2607 Manker Ave. (3)
Healey, Mrs. Robert J.
5559 Washington Blvd. (20)
Hedrick, Mrs. Philip W.
9232 N. Delaware St. (40)
Heimburger, Mrs. Robert F. 4462 Central Ave. (5)
Helmer, Mrs. O. M.....5015 N. Illinois St. (8)
Hendricks, Mrs. Fred A. 5867 N. New Jersey (20)
Henry, Mrs. R. S.....4367 Lincoln Rd. (8)
Hepburn, Mrs. Charles K.
7570 Morningside Dr. (40)
Heubi, Mrs. John E.....6904 N. Park Ave. (20)
Hickman, Mrs. Jack W.
4134 Sun Meadow Lane (8)
Hickman, Mrs. Walter F. 5959 Gladden Dr. (20)
Hilldrup, Mrs. Don G.....5672 N. Illinois St. (8)
Hogan, Mrs. Michael A.
1807 W. 72nd Pl. (50)
Holland, Mrs. Wm.....4345 N. College Ave. (5)
Holman, Mrs. Jerome E., Jr.
5930 Central Ave. (20)
Holman, Mrs. Jerome E., Sr.
4503 E. Kessler Blvd., E. Dr. (20)
Holmes, Mrs. George H., Jr.
7421 E. Frederick Dr. (60)
Hood, Mrs. Ainslee A...1810 Rosedale Drive (27)
Howell, Mrs. Joseph D.....4514 E. 79th St. (50)
Howell, Mrs. Robert D.
6941 Washington Blvd. (20)
Hoyt, Mrs. Millard L...5725 Hunterglen Rd. (26)
Hudson, Mrs. Foster J.....3865 Cheviot Pl. (18)
Hull, Mrs. Ronald H.....6252 Bramshaw Rd. (20)
Hummons, Mrs. Francis D. 4045 Clarendon Rd. (8)
Hurteau, Mrs. William W...201 West 75th St. (60)
Huse, Mrs. Wm. Murray
5131 N. Pennsylvania St. (5)

I-J

Irvine, Mrs. William O.....2609 W. 62nd St. (68)
Irwin, Mrs. Glenn W., Jr. 8025 N. Illinois St. (60)
Iske, Mrs. Paul G.....5207 Central (20)
Jaquith, Mrs. Orville S...261 Blue Ridge Rd. (8)
Jennings, Mrs. Frank L.
2601 Cold Springs Rd. (22)
Jewett, Mrs. Joe H.....5803 Sherman Ave. (20)
Jinks, Mrs. Clifford H.....1831 E. 61st St. (20)
Johnson, Mrs. Earl H.....2345 Durham Dr. (20)
Johnson, Mrs. Thomas W.
5735 Washington Blvd. (20)
Jones, Mrs. David E...5433 Hawthorne Dr. (26)
Jones, Mrs. George.. 8933 Southeastern Ave. (19)
Joseph, Mrs. Rex M.....620 Hickory Lane (27)
Jowitt, Mrs. Richard H.
5390 Brendonridge Rd. (26)
Judson, Mrs. Walter E.....844 Fleetwood Dr. (8)

K

Kalsbeck, Mrs. John E.....6115 W. 25th St. (24)
Kammen, Mrs. Leo.....7030 Central Ave. (20)
Karsell, Mrs. Wm. A...5310 Staughton Dr. (26)
Katterjohn, Mrs. James C.
9035 Pickwick Dr. (60)
Keenan, Mrs. George 2015 E. Thompson Rd. (27)
Keenan, Mrs. Reid L...3702 N. Delaware St. (5)
Keever, Mrs. Charles H., Sr.
9016 Keever Dr., R. R. 18, Box 289 B (24)
Kennedy, Mrs. Hunter F.
1147 Charleston Dr. E. (19)
Kennedy, Mrs. Joseph T.
5316 Brendonridge Rd. (26)
Kenney, Mrs. David B.....6711 E. Tenth St. (19)
Kenzler, Mrs. Jack I.....6040 E. 65th Place (20)
Kerr, Mrs. Harry R...5774 Washington Blvd. (20)
King, Mrs. Harold K...4606 Washington Blvd. (5)
Kingsbury, Mrs. John K.
5776 E. Michigan St. (19)
Kirtley, Mrs. William R...7447 N. Park Ave. (20)
Kiser, Mrs. Edgar F.....5610 Central Ave. (20)
Kissel, Mrs. Wesley A...3721 Briarwood Dr. (20)
Klain, Mrs. Benjamin V.
8419 N. Pennsylvania St. (20)
Kneidel, Mrs. J. H.....918 E. 57th St. (20)

Knowles, Mrs. Charles Y. 4340 Glencairn Ln. (18)
Kohlstaedt, Mrs. Kenneth G...645 E. 80th St. (40)
Kooiker, Mrs. John E.....3540 Watson Road (5)
Koons, Mrs. Karl M.
5767 N. Pennsylvania St. (20)
Kornafel, Mrs. Laddie H...6201 College Ave. (20)
Kuntz, Mrs. Herman W.
2065 Lick Creek Drive (3)
Kwitny, Mrs. I. J...5774 Broadway Terrace (20)

L

LaDine, Mrs. Clarence B...5417 N. Meridian (8)
Lamb, Mrs. Emmett B...1180 Golden Hill Dr. (8)
Lamber, Mrs. Chet
3965 N. Meridian, Apt. 4D (8)
Lang, Mrs. Erich K.....2045 W. 56th St. (8)
Leasure, Mrs. J. Kent
3060 N. Meridian #401 (8)
Leffler, Mrs. William T.....250 E. 70th St. (20)
LeMaster, Mrs. Theodore R.
2621 McLeay Dr. (20)
Levi, Mrs. Leon....6902 N. Pennsylvania St. (20)
Lewis, Mrs. Earl.....380 S. Kenmore Rd. (19)
Lewis, Mrs. Paul S.....6380 W. Ohio St. (24)
Lewis, Mrs. Robert J...5800 Lawrence Dr. (26)
Ley, Mrs. Glen.....3556 Guilford (5)
Lichtenberg, Mrs. Melvin
5677 N. Meridian St. (8)
Lindenborg, Mrs. Paul G.....4304 E. 46th St. (26)
Lingeman, Mrs. Raleigh E.
4235 N. Pennsylvania (8)
Lloyd, Mrs. Frank P.....4210 N. Illinois St. (8)
Lochry, Mrs. Ralph L.
5801 N. Olney St., Apt. 9 (20)
Loehr, Mrs. Wm. M...1426 E. Kessler Blvd. (20)
Lord, Mrs. Glenn C.....7437 Holliday Dr. W. (60)
Loughlin, Mrs. Leo 5616 N. Pennsylvania St. (20)
Love, Mrs. George N. 5331 Washington Blvd. (20)
Lozow, Mrs. David.....5545 N. Meridian (8)
Lukemeyer, Mrs. George T.
3845 N. Campbell Ave. (26)
Lunsford, Mrs. Thomas E.....215 E. 71st St. (20)
Lurie, Mrs. Paul R.....5 W. 79th St. (60)
Luros, Mrs. J. Theodore....156 Fairway Dr. (60)
Lybrook, Mrs. William B.
4585 Kessler Blvd., E. Dr. (20)

M

McAlpine, Mrs. Richard J.
4602 Kessler Lane (20)
McCartney, Mrs. Donald H. 410 East 56th St. (20)
McClain, Mrs. Edwin S.
416 W. 77th St. (60)
McCormick, Mrs. Charles O., Jr.
4240 Glencairn Lane (18)
McGrath, Mrs. Michael F.
6183 Washington Blvd. (20)
McLaren, Mrs. Daniel E.....4479 Barnor Dr. (26)
Mackey, Mrs. John E.....940 W. 58th St. (8)
Madden, Mrs. Robert J.....1420 Audubon Rd. (19)
Malcolm, Mrs. R. L., Jr..R. R. 17, Box 580B (23)
Manders, Mrs. Karl L.
4925 Buttonwood Crescent (8)
Manion, Mrs. Marlow W.
5132 N. New Jersey St. (5)
Manning, Mrs. Randolph
5302 N. Delaware St. (20)
Manzie, Mrs. Michael.....2687 W. 44th St. (8)
Markstone, Mrs. David H...6002 Cadillac Dr. (24)
Marshall, Mrs. Albert L., Jr.
7802 Allisonville Rd. (20)
Martin, Mrs. Loren H.
5338 Washington Blvd. (20)
Martz, Mrs. Carl D.....7926 Hawthorn Ct. (26)
Masters, Mrs. John M.....34 E. 46th St. (5)
Matthew, Mrs. W. Burleigh
800 W. Kessler Blvd. (8)
Matthews, Mrs. B. J.....966 North Graham (19)
Matthews, Mrs. William M.
1122 N. Bolton Ave. (19)
Maxam, Mrs. Beverly T. 6220 Sunset Lane (24)
Megenhardt, Mrs. Dennis S.
3038 E. Fall Creek Pkwy. N. Dr. (5)
Meiks, Mrs. Lyman T.
4203 N. Pennsylvania St. (5)
Melin, Mrs. John R.....2628 Knollwood Dr. (8)
Merrell, Mrs. Paul.....5367 Kenwood (8)
Mertz, Mrs. John H .O.....5950 Central Ave. (20)
Michael, Mrs. Isaac E. 3366 N. Kessler Blvd. (22)
Middleton, Mrs. H. N...3828 Rookwood Ave. (8)
Miller, Mrs. Jerry R...7237 Sylvan Ridge Rd. (40)
Miller, Mrs. Roscoe E.....R. R. #17, Box 503 (23)
Mitchell, Mrs. Earl N.
1222 N. Irvington Ave. (19)
Moak, Mrs. Glenn D.....2155 Weslynn Dr. (8)
Moenning, Mrs. John E.
1905 N. King Ave. (22)
Montgomery, Mrs. Ralph F...3531 N. Norfolk (24)
Montgomery, Mrs. W. Foster..4546 Park Ave. (5)
Moore, Mrs. Donald F. 1315 West 10th Street (7)
Moore, Mrs. Harold T...5802 Allisonville Rd. (20)
Morchan, Mrs. Samuel.....7007 Broadway (20)
Moriarity, Mrs. John.....6130 Smock Dr. (27)
Morrison, Mrs. Lewis E., II..4450 Park Ave. (5)
Morton, Mrs. Joseph L.....3272 W. 42nd St. (8)
Morton, Mrs. Walter P.
3434 E. Fall Creek Blvd., N. Dr. (5)
Moss, Mrs. H. C.....4802 Washington Blvd. (5)
Mothersill, Mrs. Mark H.....3650 College Ave. (5)
Mouser, Mrs. Robert W.
5555 N. Meridian St. (8)
Muller, Mrs. Lullus P.
5675 Washington Blvd. (20)

N

Nagan, Mrs. Robert F.....3902 Devon Dr. (18)
Nay, Mrs. Richard M.....5525 N. Meridian (8)
Need, Mrs. Louis T.....3627 Bluff Rd. (27)
Nester, Miss Lena Laura
5324 N. Pennsylvania St. (20)
Nie, Mrs. Louis W.....4305 Central Ave. (5)
Nohl, Mrs. John M.....5410 Eastridge Dr. (19)
Nolting, Mrs. Henry F...155 W. Hampton Dr. (8)
Norris, Mrs. Max S.....540 E. 36th St. (5)
Nourse, Mrs. Myron H.
8064 Morningside Dr. (20)
Nugent, Mrs. Edwin J...6840 N. Delaware St. (20)
Nurnberger, Mrs. John I.
5215 Washington Blvd. (20)

O

O'Brian, Mrs. Earl J.
4525 Crooked Creek Ridge Rd. (8)
Ochsner, Mrs. Harold C.
4565 Cold Spring Rd. (8)
Offutt, Mrs. Andrew C. 750 N. Campbell Ave. (19)
Olvey, Mrs. Ottis N.....5428 Central Ave. (20)
Otten, Mrs. Claude F..5222 Washington Blvd. (20)
Overley, Mrs. Toner M., Jr...3501 Watson Rd. (5)
Owens, Mrs. Tracy C.....2823 N. Meridian St. (8)

P

Palmer, Mrs. Harley P.. 7611 E. Penway St. (26)
Parr, Mrs. Robert L.....4407 Dickson Rd. (20)
Paulissen, Mrs. George T.....741 Markwood (27)
Paynter, Mrs. Morris B.....115 Roberts Rd. (27)
Peck, Mrs. Franklin B., Jr.
8181 Lincoln Blvd. (20)
Peirce, Mrs. James D.
5027 Washington Blvd. (20)
Pennington, Mrs. Walter E.
5910 Carrollton Ave. (20)
Permer, Mrs. Erwin.....5590 Grandview Dr. (8)
Peters, Mrs. Robert J. D.
3203 E. Michigan St. (1)

Petranoff, Mrs. Theodore V.
2814 Questend—S. Dr. (22)
Pfaff, Mrs. O. G.....4605 N. Meridian St. (8)
Pickett, Mrs. Robert D...4713 Millersville Rd. (26)
Pierce, Mrs. Emmett....1034 N. Bolton Ave. (19)
Pierce, Mrs. Raymond O., Jr..1521 W. 25th St. (8)
Pilcher, Mrs. Jack E.....4601 Graceland Ave. (8)
Pontius, Mrs. Edwin E.
6221 Avalon Lane, E. Dr. (20)
Popplewell, Mrs. Arvine G.
141 E. Southport Rd. (27)
Powell, Mrs. Richard C...6535 Munsee Lane (60)
Price, Mrs. Francis W.
550 East Edgewood Ave. (27)
Price, Mrs. Walter S..8430 Washington Blvd. (40)
Pryor, Mrs. Richard C...6134 Carrollton Ave. (20)

R

Rabb, Mrs. Frank M.....4619 Dickson Rd. (26)
Raber, Mrs. Robert M.....265 Williams Ct. (20)
Rader, Mrs. George S.....3778 E. 62nd St. (20)
Rafalski, Mrs. Thomas A.
3135 Shady Grove Court (22)
Ragan, Mrs. William D...2157 Wilshire Road (8)
Ramsey, Mrs. Frank B.....1401 W. 52nd St. (8)
Rawls, Mrs. George H.....4226 N. Illinois St. (8)
Reed, Miss Ann.....4131 N. Meridian (8)
Reed, Mrs. Philip B.....4131 N. Meridian St. (8)
Rees, Mrs. Russell C.
926 Ellenberger Pkwy., W. Dr. (19)
Reid, Mrs. Charles A.....6506 Madison Ave. (27)
Rhamy, Mrs. Robert K.....2806 E. 65th St. (20)
Rice, Mrs. Frederic A., Jr...5802 E. 46th St. (26)
Rice, Mrs. Raymond D.
5241 Washington Blvd. (20)
Rice, Mrs. Raymond M.
7799 E. Holliday Drive (20)
Ridolfo, Mrs. Anthony S.....6139 Maren Dr. (24)
Robb, Mrs. John A...5151 N. Pennsylvania St. (5)
Rochlin, Mrs. I.....5005 Kenwood (8)
Roesch, Mrs. Ryland.....5444 N. Illinois St. (8)
Rogers, Mrs. Donald L.
2618 Bluffwood Dr., W. (8)
Roll, Mrs. John W.....6340 Bramshaw (26)
Roller, Mrs. Charles W.....2301 Garfield Dr. (3)
Romberger, Mrs. Floyd T., Jr..10 W. 64th St. (20)
Rosenak, Mrs. Bernard D.
5254 N. Delaware St. (20)
Ross, Mrs. Alexander T. 6050 Knyghton Rd. (20)
Ruddell, Mrs. Karl R...2626 N. Meridian St. (8)
Ruddell, Mrs. Keith R..1201 Golden Hill Drive (8)
Rudesill, Mrs. Robert L. 5311 N. Pennsylvania (20)
Rupel, Mrs. Ernest.....5735 N. Meridian (8)
Rust, Mrs. Byron K...8401 Washington Blvd. (40)
Rust, Mrs. Roland B., Jr...6640 Sunny Lane (20)
Ruth, Mrs. Martin L.....7 N. Colorado Dr. (1)
Ryan, Mrs. C. David.....3524 Welch Dr. (24)
Ryan, Mrs. Glen V.
3168 E. Fall Creek Pkwy., N. Dr. (5)

S

Sage, Mrs. Russell A...7531 Morningside Dr. (40)
Salb, Mrs. Max C.....6741 Allisonville Rd. (44)
Sanders, Mrs. Fred.....4575 Ayrshire Dr. (8)
Saperstein, Mrs. Morris..5300 N. Meridian St. (8)
Schermer, Mrs. Kenneth L.
5845 N. Sherman Dr. (20)
Schlaegel, Mrs. T. F.....4536 Dickson Rd. (26)
Schlegel, Mrs. Donald M.....4042 Cranbrook (40)
Schmidt, Mrs. Loren F. 5880 Carrollton Ave. (20)
Schmalhausen, Mrs. A. W. 5009 Dickson Rd. (26)
Schmoyer, Mrs. M. Ray 7338 N. Audubon Rd. (20)
Schneider, Mrs. Carl J.....340 N. Kenyon (19)
Schnute, Mrs. Richard 5460 Broadmoor Plaza (8)
Schuchman, Mrs. Gabriel..5944 Central Ave. (20)
Schuster, Mrs. Dwight.4503 Washington Blvd. (5)
Scofield, Mrs. John B.....9014 Pickwick (60)
Scott, Mrs. George E.....4110 Roland Rd. (18)
Scott, Mrs. Jasper P.....5840 Winthrop Ave. (20)
Scott, Mrs. John R.....7966 N. Illinois St. (20)
Scott, Mrs. Robert P.
5715 N. Pennsylvania St. (20)
Seaman, Mrs. Charles F. 5353 Channing Rd. (20)
Sedam, Mrs. Herbert L. 4819 Millersville Rd. (26)
Segar, Mrs. William E.....4855 Victoria Rd. (8)
Sellmer, Mrs. George.....8760 Driftwood (40)
Sexson, Mrs. Hiram T...5455 N. Meridian St. (8)
Shafer, Mrs. Marion R. 6290 Allisonville Rd. (20)
Shapiro, Mrs. Burton J. 525 Woodmere Dr. (20)
Shelley, Mrs. R. J.....5810 E. 46th St. (26)
Shipley, Mrs. Edward C.....3601 Marrison Pl. (5)
Shullenberger, Mrs. Wendell A.
4535 Central Ave. (5)
Shumacker, Mrs. Harris B., Jr.
6834 N. Pennsylvania St. (20)
Sicks, Mrs. Okla W.....607 E. 82nd (40)
Siderys, Mrs. Harry
5102 N. Pennsylvania St. (20)
Siersdorfer, Mrs. T. N...5559 W. Morris St. (41)
Sigmond, Mrs. Harvey..3245 N. Pennsylvania (5)
Silver, Mrs. Richard A. 7421 E. Frederick Dr. (8)
Sims, Mrs. J. Lawrence....3723 N. Gale St. (18)
Sluss, Mrs. David.....3657 Washington Blvd. (5)
Smith, Mrs. E. Rogers.....160 W. 47th St. (8)
Smith, Mrs. Roy Lee..1427 West Stop 11 Rd. (27)
Snider, Mrs. Byron.....2717 S. East St. (3)
Solomon, Mrs. Reuben A.
5330 N. Pennsylvania (20)
Soper, Mrs. Hunter A.....5321 Boulevard Pl. (8)
Sovine, Mrs. Joe W.....8182 N. Illinois St. (20)
Spahr, Mrs. John F., Jr.
3014 Green Hills Lane, N. Dr. (22)
Sparks, Mrs. Alan L.
5466 N. Pennsylvania St. (20)
Spears, Mrs. John M.....6910 Shelby (27)
Speckman, Mrs. Glenn H.....5242 Park Ave. (20)
Sputh, Mrs. Carl B., Jr.
5671 Rolling Ridge Rd. (20)
Stansbury, Mrs. Wm. E.....5610 E. 16th St. (18)
Stayton, Mrs. Chester A., Sr..6931 Central (20)
Stayton, Mrs. Chester A., Jr.
7065 Central Ave. (20)
Stephens, Mrs. Donald E.....5555 Broadway (20)
Stone, Mrs. Alvin T.....5727 Broadway (20)
Storey, Mrs. D. Edmund
808 Forest Blvd., N. Dr. (20)
Storms, Mrs. Roy B.....5041 Central Ave. (5)
Strang, Mrs. Wm. C.....7760 Cree Trail (50)
Stroup, Mrs. Tyler J...5758 N. College Ave. (20)
Stucky, Mrs. Elsworth K.
4528 N. Meridian St. (8)
Stump, Mrs. Loyd K.....6375 Brixton Lane (20)
Suelzer, Mrs. John.....4041 Milbourne St. (8)
Sullivan, Mrs. James J.....3458 Welch Dr. (24)
Summerlin, Mrs. Jack D.
6375 Avalon Lane, E. Dr. (20)
Sutton, Mrs. William E...5670 Guilford Ave. (20)
Swan, Mrs. John R.....320 Arden Dr. (20)

T

Talbott, Mrs. Dan E.....6470 N. Michigan Rd. (8)
Tanner, Mrs. Henry S.
4461 N. Pennsylvania St. (5)
Taube, Mrs. Jack I...4353 N. Pennsylvania St. (5)
Taylor, Mrs. Clifford C.
3720 Briarwood Dr., E. (20)
Taylor, Mrs. Frederic W.....40 E. 43rd St. (5)
Teague, Mrs. Frank W.....555 W. Pine Dr. (60)
Tepfer, Mrs. Milton..3031 N. Centennial St. (22)
Tether, Mrs. J. Edward.....4839 E. 56th St. (20)
Tharpe, Mrs. Ray G.....6161 Sunset Lane (8)
Thatcher, Mrs. Hugh K., Jr...408 E. 45th St. (5)
Thoman, Mrs. Rex L.....4969 W. 11th St. (24)
Thomas, Mrs. Charles R...7029 Wayland Dr. (39)
Thomas, Mrs. E. P.....6235 Grandview Dr. (60)
Thomas, Mrs. Fred A.....5827 Broadway (20)
Thomas, Mrs. Lowell I.....28 W. Hampton Dr. (8)

Thomas, Mrs. Morris E.
6215 Spring Mill Rd. (20)
Thompson, Mrs. John V.....7899 Ridge Rd. (20)
Thompson, Mrs. Paul D.
5939 Hillside Ave., E. Dr. (20)
Thompson, Mrs. Wayne..6365 Knyghton Rd. (20)
Throop, Mrs. Frank B.....57 E. 38th St. (5)
Thurston, Mrs. A. L.....4078 Central Ave. (5)
Tinsley, Mrs. Walter B., Sr. 5638 Broadway (20)
Tinsley, Mrs. Walter B., Jr.
4505 Melbourne Rd. (8)
Tischer, Mrs. E. Paul.....6801 Dean Rd. (20)
Tondra, Mrs. John M.....4511 Broadway (5)
Torrella, Mrs. Jose A.....5721 W. 18th St. (24)
Trudgen, Mrs. Spencer F..7602 Woodside Dr. (60)
Trusler, Mrs. Harold M.
6150 N. Meridian St. (20)
Trusler, Mrs. H. Marshall..4714 W. 30th St. (22)
Tucker, Mrs. Warren S.
5338 N. Pennsylvania St. (20)
Tyler, Mrs. Edward.....5693 N. Meridian St. (8)

U-V

Ullom, Mrs. Ralph.....520 Wayside Dr. (60)
Van Denbark, Mrs. Howard..3268 Patton Dr. (24)
Vandivier, Mrs. Robert M.
3715 N. Meridian St. #1 (8)
Van Meter, Mrs. C. Powell
4102 Marrison Place (18)
VanOsdol, Mrs. Harry A.
43 W. Hampton Dr. (8)
Van Tassel, Mrs. C. J., Jr.
5832 Washington Blvd. (20)
Vollrath, Mrs. Victor J.
7980 N. Pennsylvania St. (20)
Von Der Haar, Mrs. Gerard
1109 N. Mitchner St. (19)
Vore, Mrs. Robert E.....3710 Cheviot Place (5)

W

Wainscott, Mrs. Clinton S.
5332 Channing Road (26)
Waldo, Mrs. J. Thayer.....420 W. 64th St. (8)
Walther, Mrs. Joseph E.
4266 N. Pennsylvania St. (5)
Walton, Mrs. William M.
8007 N. Illinois St. (60)
Warneke, Mrs. Charles.....2533 Ryan Dr. (20)
Warriner, Mrs. James B...990 N. Bolton Ave. (19)
Warvel, Mrs. John H.
4360 Kessler Blvd., N. Dr. (8)
Washington, Mrs. Wilbert.....1051 Brooks (2)
Weiss, Mrs. Jason.....2790 W. 38th (8)
West, Mrs. Joseph L.....2110 W. 38th St. (8)
Westfall, Mrs. B. Kemper, Jr.
4001 N. Meridian St. (8)
Wheeler, Mrs. David E.
5441 Brendonridge Rd. (26)
White, Mrs. Donald J. 5430 N. Delaware St. (20)
White, Mrs. Douglas H., Jr.
7405 Frederick Dr. East (60)
White, Mrs. J. Philip.....6180 Carvel Ave. (20)
White, Mrs. John B.....5850 Highfall Rd. (26)
Wilkens, Mrs. Irvin W.
4820 E. Pleasant Run Pkwy., N. Dr. (1)
Williams, Mrs. Charles D...160 E. 71st St. (20)
Williams, Mrs. Howard S., Jr.
3824 N. Delaware St. (5)
Williams, Mrs. Hugh L...6231 Knyghton Rd. (20)
Wirey, Mrs. Harold R...2949 E. Hanna Ave. (27)
Wise, Mrs. William R.....1908 Orlando (8)
Wishard, Mrs. William N., Jr.
5720 N. Pennsylvania St. (20)
Witham, Mrs. Robert L.....5811 Ravine Rd. (20)
Woerner, Mrs. Thos. E..7981 Dartmouth Rd. (60)
Wolfram, Mrs. Don J.
5716 N. Pennsylvania St. (20)
Wood, Mrs. Donald E...6467 W. Holliday Dr. (20)
Woolling, Mrs. Kenneth R..5751 Central Ave. (20)
Worley, Mrs. J. P.....6797 E. 10th St. (19)
Worley, Mrs. R. H.....4626 Cavendish Rd. (20)
Wrege, Mrs. Malcolm..5411 Shorewood Dr. (20)

Y-Z

Yacko, Mrs. Michael L.
5341 N. Channing Rd. (26)
Yingling, Mrs. Robert J..5322 Hedgerow Dr. (26)
Young, Mrs. James W.....440 E. 71st St. (20)
Young, Mrs. John M.
4535 Marcy Lane, No. 261 (5)
Young, Mrs. John T.....3030 Rex Dr. (22)
Zell, Mrs. Evertson H...4747 Millersville Rd. (26)
Zerfas, Mrs. Charles P. A.....R. 1, Box 220 (27)

Kendrick, Mrs. William M...R. R. 1, Mooresville
Asher, Mrs. Ernest O.....4640 W. 71st St., New Augusta
Asher, Mrs. James W.....R. R. 16, Box 355, New Augusta
Brooks, Mrs. Fred.....1660 Cunningham Dr., Speedway (24)
MacDougall, Mrs. John D.....R. R. 1, Box 170B, Westfield

MARSHALL COUNTY

Hampton, Mrs. James N.....R. R. 2, Argos
Kemp, Mrs. William....1006 N. Main St., Bourbon
Bowen, Mrs. Otis R...304 N. Center St., Bremen
Burket, Mrs. Cecil R.....121 E. Grant St., Bremen
Stine, Mrs. Marshall.420 Shumaker Dr., Bremen
Hippensteel, Mrs. Russell R.
936 South Shore Rd., Culver
Howard, Mrs. Joseph.....212 Cass St., Culver
Vore, Mrs. L. W.....R. R. 4, Myers Lake

Plymouth

Coursey, Mrs. James.....R. R. 2, Box 282A
France, Mrs. Lloyd C.....R. R. 2, Goshen Rd.
Guild, Mrs. Kent.....800 N. Center St.
Kubley, Mrs. James.....624 E. LaPorte
Peterson, Mrs. Ronald.....R. R. 2
Reed, Mrs. Robert G.....235 Hogarth
Reno, Mrs. Edward.....700 Ferndale
Rimel, Mrs. James F.....909 Bayless
Robertson, Mrs. James S.....1081 Highland Ct.

MIAMI COUNTY

Shrock, Mrs. E. E.....Amboy
Crates, Mrs. Gordon.....Chili
Line, Mrs. Homer.....Chili
Sixbey, Mrs. Maurice.....Box 68, Chili
Rendel, Mrs. H. E.....Mexico

Peru

Barnett, Mrs. Helen.....109 W. Seventh St.
Guthrie, Mrs. James U.....331 W. Third St.
Herd, Mrs. Cloyn R.....16 Farview
Hill, Mrs. Lloyd L.....984 E. Jackson
Johnson, Mrs. Owen B.....106 W. Sixth St.
Malouf, Mrs. S. D.....359 W. Third St.
Snyder, Mrs. Parker W.....159 W. Sixth St.
Wildman, Mrs. R. E.....R. R. 2
Yarling, Mrs. Francis.....117 E. Fifth St.

MONTGOMERY COUNTY

Crawfordsville

Baird, Mrs. Keith.....811 W. Main St.
Burks, Mrs. Jess E.....512 W. Wabash Ave.
Cooksey, Mrs. Thomas L.....205 Marshall
Cornell, Mrs. Robert A.....1000 S. Washington
Daugherty, Mrs. Fred N.....415 W. Main St.
Eggers, Mrs. Richard R.....203 S. West St.
Haller, Mrs. Thomas C.....508 W. Main St.
Humphreys, Mrs. John W.....1309 Durham Dr.

Kinnaman, Mrs. Howard.....R. R. 5
Kirtley, Mrs. James M.....615 Thornwood Rd.
Lingeman, Mrs. Byron N.....203 Wallace Ave.
Ludwig, Mrs. Paul E.....Country Club Rd.
Millis, Mrs. Samuel C.....201 Wallace Ave.
Peacock, Mrs. Norman F.....111 Wallace Ave.
Pierson, Mrs. Robert H.....305 E. Main St.
Richards, Mrs. Edgar E.....Danville Rd., R. R.
Shannon, Mrs. Wesley E.....6 Locust Hill Dr.
Sharp, Mrs. John L.....1113 Durham Dr.
Viray, Mrs. V. G.....809 North Dr.
Wallace, Mrs. Hawthorne C...107 W. Jefferson St.

Otten, Mrs. Ralph E.....Darlington
Smith, Mrs. Byron J.....Kingman
Blix, Mrs. Fred.....Ladoga
Kindell, Mrs. Hurschell D.....New Richmond
Hales, Mrs. R. E.....Roachdale
Rusk, Mrs. Hubert M.....Box 36, Wallace
Thompson, Mrs. Claude N.....Waynetown
Parker, Mrs. Carl B.....Wingate

MORGAN COUNTY

Martinsville

Eisenberg, Mrs. David....Box 310, Sunnyside Dr.
Gray, Mrs. Leon.....589 Valley Drive N.
Merchon, Mrs. Jack B.....490 Virginia St.
Miller, Mrs. Ray D.....290 E. Washington St.
Miller, Mrs. Robert J.....589 S. Jefferson St.
Ostheimer, Mrs. George J. 215 E. Washington St.
Pitkin, Mrs. Edward.....309 E. Washington St.
Pitkin, Mrs. McKendree C...440 E. Washington St.
Reese, Mrs. Jay S.....St. Rd. 67
Sweet, Mrs. Austin.....260 N. Wayne
Van Wienan, Mrs. John.....439 N. Jefferson
Willan, Mrs. Horace R.....109 S. Jefferson
Winter, Mrs. William.....269 E. Green

Mooresville

Bivin, Mrs. James H.....N. Indiana Rd.
Comer, Mrs. Charles W.....R. R. 2
Comer, Mrs. Kenneth E.....R. R. 2
Van Bokkelen, Mrs. Robert W...124 S. Indiana St.

Murphy, Mrs. M. G.....Box 167, Morgantown
Wilson, Mrs. Oliver R.
Box 65, R. R. 3, Morgantown

NEWTON COUNTY

Schoonveld, Mrs. Arthur.....Brook
Parker, Mrs. John.....Goodland
Kresler, Mrs. L. E.....301 N. Sixth St., Kentland
Yegerlehner, Mrs. R. S.....146 W. Graham St., Kentland
Guzman, Mrs. Marc.....Morocco

NOBLE-LaGRANGE COUNTIES

Bowman, Mrs. Charles M. 202 E. Main St. Albion
Nash, Mrs. Justin R.....202 N. Orange, Albion
Williams, Mrs. C. E.....R. R. 1, Albion
Taylor, Mrs. Millard R.....Howe
Yunker, Mrs. Philip.....Box 188, Howe
Gutstein, Mrs. Richard R.
120 Diamond, Kendallville
Seybert, Mrs. J. D...117 S. Riley St., Kendallville
Williams, Mrs. H. O.
735 Mitchell St., Kendallville
Benedict, Mrs. Charles D.
R. R. 1, Box 14, LaGrange
Miller, Mrs. Jerry Allen
Woodring Dr., East LaGrange
Studebaker, Mrs. Lloyd R.
325 W. Spring, LaGrange
Hooker, Mrs. Donald J...406 S. Main St., Ligonier
Stone, Mrs. Robert C.....501 S. Main St., Ligonier
Stultz, Mrs. Quentin F...3 Hawthorn Dr., Ligonier
Williams, Mrs. John H.
221 Van Buren, Shipshewana
Luckey, Mrs. Robert C.....Wolf Lake

ORANGE COUNTY

Hagan, Mrs. Marion L.....Main St. French Lick
Sugarman, Mrs. Benjamin E.
417 Walnut St., French Lick
Manship, Mrs. C. Stanley...214 W. Main St. Paoli
Spears, Mrs. John K.....312 N. Gospel St., Paoli

OWEN-MONROE COUNTIES

Bloomington

Austin, Mrs. Rayburn C.....114 S. Grant
Baxter, Mrs. Neal E.....515 Hawthorne
Bomba, Mrs. Brad.....150 Sunny Slopes
Booze, Mrs. James H.....Fieldcrest
Borland, Mrs. Raymond M.....R. R. 3, Box 51
Buck, Mrs. Roger L.....MelCurry Pike
Cochran, Mrs. John F.....113 N. Concord Rd.
Emery, Mrs. Charles B., Jr.....1316 S. High St.
Estes, Mrs. Ambrose.....701 Highland Ave.
Farr, Mrs. James C.....1310 Pickwick Pl.
Fowler, Mrs. R. Ross.....Pleasant Ridge Rd.
Geiger, Mrs. Dillon.....1704 N. Fee Lane
Hardtke, Mrs. Eldred F.....1400 Pickwick Place
Hibner, Mrs. Kermit Q.....1306 Pickwick Pl.
Houshmand, Mrs. Cyrus.....102 N. Glenwood Dr.
Manifold, Mrs. Harold M.....1310 S. Nancy St.
Miller, Mrs. John M.....1402 Winfield Rd.
Poolitsan, Mrs. George.....1217 E. First St.
Rieger, Mrs. I. Taylor.....Woodcrest Dr.
Schell, Mrs. H. Richard.....1401 Maxwell Lane
Seagle, Mrs. W. Courtney.....1710 N. Walnut
Sibbitt, Mrs. Joseph W.....818 Sheridan
Smith, Mrs. Herschel S.....200 Glendora Dr.
Taraba, Mrs. Ralph.....211 E. Martha St.
Topolgus, Mrs. James N.....1015 Atwater Ave.

PARKE-VERMILLION COUNTIES

Clinton

DeRenne, Mrs. Wm. L.....559 Main St.
Evans, Mrs. F. J.....1315 S. Main St.
Gailey, Mrs. I. L.....257 Walnut St.
Gerrish, Mrs. W. D.....125 S. Fifth St.
Herzberg, Mrs. Milton.....545 S. Fourth St.
Kercheval, Mrs. J. M.....Box 192
Somerville, Mrs. John W.....R. R. 2

Webb, Mrs. L. C.....Dana
Britton, Mrs. W. D. Bloomingdale Rd., Montezuma

Rockville

Beebe, Mrs. Milton O., Jr.....9 Valley Dr.
Bloomer, Mrs. Joseph R.....115 N. Market
Bloomer, Mrs. Richard S.....502 W. York St.
Kempf, Mrs. Gerald F.....Indiana State Hospital for Chest Diseases
Minich, Mrs. William G.....617 Woodland Dr.

PERRY-SPENCER COUNTIES

Bush, Mrs. Hargis R.....Sixth St., Cannelton
Gilbert, Mrs. Robert G.
411 E. Seventh St., Cannelton
Glackman, Mrs. John C. 207 Center St., Rockport
Snyder, Mrs. Earl.....Troy

Tell City

Dukes, Mrs. David A.....521 Main St.
Glenn, Mrs. Fred C.....436 Main St.
Herr, Mrs. William J.....Boyd Road
James, Mrs. John M.....24 11th St.
James, Mrs. Nicholas A.....740 Ninth St.

Kemker, Mrs. Bernard P.....Tell Street Rd.
Lally, Mrs. Bernard.....918 Main St.
Lashley, Mrs. Donald L.....606 Ninth St.
Lohoff, Mrs. Lewis C.....425 10th St.
Neifert, Mrs. Noel L.....1118 Blum St.
Ress, Mrs. Gene E.....13th St.
Smith, Mrs. Fred, Jr.....1407 12th Street

PORTER COUNTY

Chesterton

Griffin, Mrs. Joseph.....419 S. Jackson
Hall, Mrs. Thomas.....16 Ridge Dr., Dune Acres
Harless, Mrs. C. M.....123 W. Indiana Ave.
Read, Mrs. John E.....Wilson St.
Robertson, Mrs. W. C.....600 E. Morgan

Valparaiso

Brown, Mrs. J. C.....1808 Napoleon
Carlson, Mrs. M. R.....2206 Vine St.
DeGrazia, Mrs. E. J.....410 Washington St.
Douglas, Mrs. George R.....404 Washington St.
Eades, Mrs. Ralph.....203 Jefferson St.
Frank, Mrs. John R.....303 Indiana Ave.
Gold, Mrs. Marvin E.....1407 Washington St.
Klos, Mrs. Stanley J.....R. R. 2, Box 286
LaRocca, Mrs. Joseph.....402 Erie
Makovsky, Mrs. Theodore..1807 Beulah Vista Dr.
O'Neill, Mrs. Martin J.....301 Washington St.
Sacks, Mrs. Leonard Z.....563 Ravine Dr.
Vietzke, Mrs. Paul C. F.....1302 Summit Pl.
Wu, Mrs. Stewart.....102 Mayfield Ave.

PUTNAM COUNTY

Veach, Mrs. Richard L.....Bainbridge
Gray, Mrs. Clyde C.....Cloverdale
Ellett, Mrs. John.....Box 126, Coatesville

Greencastle

Dettloff, Mrs. Frederick R.....300 Highfall Ave.
Johnson, Mrs. James B.....314 Highfall Ave.
Schauwecker, Mrs. Cleon M.....613 Ridge Ave.
Smith, Mrs. A. Wilson.....R. F. D. 2
Steele, Mrs. Dick J.....207 Northwood Blvd.
Stephens, Mrs. James P.....R. R. 3
Tennis, Mrs. George T.....602 S. Jackson
Tipton, Mrs. William R.....103 Northwood Blvd.
Wiseman, Mrs. V. Earle.....6 Durham Ave.

RANDOLPH COUNTY

Farmland

Nixon, Mrs. Byron.....312 N. Main
White, Mrs. Harvey E.....200 S. Main

Shallenberger, Mrs. H. R.....Modoc
Potter, Mrs. Richard M.
120 N. Walnut, Ridgeville

Union City

Chambers, Mrs. Carol R.....1000 N. Columbia St.
Chambers, Mrs. Leroy B.....800 N. Columbia St.
Landon, Mrs. David J.....623 N. Columbia St.
Phipps, Mrs. Leland K.....R. R. 1, Box 63A
Reid, Mrs. Robert W.....706 W. Division
Wagoner, Mrs. B. D.....409 N. Columbia St.

Winchester

Dininger, Mrs. William S.....303 S. Main St.
Engle, Mrs. Russell B.....R. R. 2
Painter, Mrs. Lowell W.....507 S. Main St.
Slick, Mrs. C. R.....512 S. Oak St.
Sparks, Mrs. Paul W.....601 W. Will
Sullivan, Mrs. Daniel.....412 W. Franklin St.

RUSH COUNTY

McNabb, Mrs. George B.....Carthage
Smith, Mrs. Stephen D...4 Maple Ln., Knightstown
Worth, Mrs. C. Willard.....Milroy

Rushville

Atkins, Mrs. C. C.....410 N. Perkins
Corpe, Mrs. Kenneth F.....R. R. 4
Deerhake, Mrs. William A.....501 N. Harrison
Denny, Mrs. Melvin.....R. R. #1
Ellis, Mrs. Davis W.....1102 Sugar Hill Dr.
Green, Mrs. Frank H.....516 N. Morgan
Hoover, Mrs. Eugene.....501 N. Harrison
Johnson, Mrs. Robert.....841 N. Harrison
McKee, Mrs. Harry G.....1109 N. Arthur St.
Norris, Mrs. Marvin.....1107 N. Main St.
Schneider, Mrs. Marvin.....431 N. Perkins St.
Shanks, Mrs. Roy E.....1110 N. Morgan

ST. JOSEPH COUNTY

Houser, Mrs. D. S.
24751 N. Riley Rd., North Liberty
Smith, Mrs. Lee.....21620 Leeper Rd., Lakeville

Mishawaka

Barone, Mrs. C. V.....59053 Bremen Highway
Ganser, Mrs. Richard A.....1020 Wilson Blvd.
Gerig, Mrs. E. Lavern.....713 W. 11th St.
Goethals, Mrs. Charles J.....602 Lincoln Way W.
McDonald, Mrs. R. M.....12252 E. Jefferson Road
Orr, Mrs. W. Robert.....1335 Prospect Dr.
Reed, Mrs. Robert.....903 Homewood
Rosenwasser, Mrs. Jacob.....834 Lincoln Way E.
Sirlin, Mrs. Edward M.....3636 Terry Lane
Spalding, Mrs. Wendell L.....60100 S. Fir Road
Stringer, Mrs. D. D.....1035 Lincoln Way E.
Templeton, Mrs. Ames R.....522 Calhoun St.
Walerko, Mrs. Frank M.....515 N. Clay St.
Walters, Mrs. Charles E.....16166 Ireland Rd.
Whitlock, Mrs. Francis C.....304 Lincoln Way E.
Whitlock, Mrs. Merle E.....16146 Chandler Blvd.
Wurster, Mrs. H. C.....221 E. Third St.
Zimmer, Mrs. Henry J.....333 Edgewater Dr.

Hillman, Mrs. Marion W.....Box 473, Westville

Spenner, Mrs. Raymond W.
R. R. 3, Diamond Lake, Cassopolis, Mich.

South Bend

A

Acker, Mrs. Robert B.....103 S. Ironwood Dr.
Arisman, Mrs. R. K.....1615 E. Colfax Ave.

B

Backs, Mrs. Alton J.....1831 N. Kessler Blvd.
Bartsch, Mrs. Harvey L.....61397 S. Miami Rd.
Beach, Mrs. Norman.....1903 Trent Way
Bebensee, Mrs. Donald.....53263 Ironwood Dr.
Bechtold, Mrs. Samuel E.....313 Pendle St.
Bell, Mrs. H. D.....1357 E. Champeau St.
Bell, Mrs. R. L.....109 S. Ellsworth
Bennett, Mrs. Jene R.....1826 E. Jefferson Blvd.
Berke, Mrs. Robert D.....1420 E. Jefferson Blvd.
Biasini, Mrs. Ben A.....19585 Glendale Road
Bickel, Mrs. David A.....1335 E. Wayne St. N.
Birmingham, Mrs. P. J... 61490 Meadowlark Lane
Bixler, Mrs. Louis C.....1817 Portage Ave.
Bodnar, Mrs. Leslie M.....1843 Portage Ave.
Bogan, Mrs. Wm. C.....1512 Hass Dr.
Booth, Mrs. Franklin M.....531 Edgewater Dr.
Borough, Mrs. Lester D.....24030 Cleveland Rd.
Brechtl, Mrs. H. J.....2305 E. Washington
Buchanan, Mrs. Wallace D. 1326 E. Wayne St., N.
Buechner, Mrs. Fred W.....603 W. Marion St.
Buslee, Mrs. Roger M.....1331 E. South St.
Butts, Mrs. Milton A.....744 N. Jacobs St.

C

Carter, Mrs. F. R. N.....2000 E. Jefferson Blvd.
Cassady, Mrs. John R.....2225 Riverside Dr.
Cassady, Mrs. J. Vernal.....2216 E. Madison
Chamblee, Mrs. Roland W.....53287 Ironwood Rd.
Clark, Mrs. William H.....1227 Garland Rd.
Colip, Mrs. George D.....260 David St.
Cook, Mrs. Gordon C.....1620 Southwood Ave.
Custer, Mrs. Edward W.....52383 N. Laurel Rd.

D

Davis, Mrs. Edward A.....52820 Kenilworth Rd.
Denham, Mrs. Robert H., Jr.....1515 E. Colfax
DeVoe, Mrs. K. R.....52978 Highland Dr.
Dingley, Mrs. Albert, Jr.....1309 E. Wayne St. S.
Dodd, Mrs. Robert D.....1510 Tudor Lane
Dolezal, Mrs. Bernard J.....815 Park Ave.
Donnelly, Mrs. Everett F. 1246 E. Jefferson Blvd.
Dunlap, Mrs. D. Logan....123 W. North Shore Dr.

E

Eades, Mrs. R. Charles.....232 Marquette Ave.
Ebin, Mrs. J. L.....1223 N. Lawrence St.
Edwards, Mrs. Bernard E.....1340 Garland Rd.
Egan, Mrs. Sherman L.....944 Riverside Dr.
Engel, Mrs. Howard R.....1112 S. 20th
English, Mrs. J. Paul.....3116 Robinhood Lane
Ericksen, Mrs. L. G.....1212 E. Woodside
Erickson, Mrs. G. Walter....3012 Robinhood Lane

F

Feferman, Mrs. Martin E.....125 S. Esther St.
Feldman, Mrs. Max.....1310 E. Fairview
Filipek, Mrs. Walter J.....2513 Lincoln Way W.
Firestein, Mrs. Ben Z.....125 W. Marion St.
Firestein, Mrs. Ray.....502 N. Ironwood Dr.
Fish, Mrs. Edson C.....19054 Summers Dr.
Foley, Mrs. Hansel.....1314 Leeper
Forrest, Mrs. O. Norman.....52725 Arbor Dr.
Frank, Mrs. Herbert....2616 S. Twyckenham Dr.
Frank, Mrs. L. L., Sr.....534 N. Lafayette Blvd.
Frank, Mrs. L. L., Jr.....1750 N. Wilbur
Frash, Mrs. D. W.....1912 Miami St.
Frey, Mrs. William B.....1714 E. Bader
Friedman, Mrs. Morris S...1617 E. Jefferson Blvd.

G

Gaffney, Mrs. Raymond.....534 Peashway St.
Gates, Mrs. George E...411 W. North Shore Dr.
Gilman, Mrs. Marcus M...1925 E. Jefferson Blvd.
Godersky, Mrs. George E.....2744 Sampson St.
Goraczewski, Mrs. T. C.....1016 W. Washington
Graf, Mrs. John P.....53260 Placid Dr.
Green, Mrs. G. Richard.....1515 E. Wayne St.
Green, Mrs. George F.....754 Country Club Lane
Green, Mrs. Norvel E.....1726 E. LaSalle Ave.
Grove, Mrs. James H.....60268 Mayflower Rd.

H

Haley, Mrs. George M.....19120 Montrose Dr.
Hamilton, Mrs. Charles O.
1418 E. Washington Ave.
Haugseth, Mrs. Ellsworth K...820 N. Ironwood Dr.
Hawkins, Mrs. Glen E.....17280 Parker Ave.
Helmer, Mrs. John.....315 W. North Shore Dr.
Hildebrand, Mrs. J. O.....1637 Southbrook Dr.
Hill, Mrs. Theodore.....107 N. Eddy St.
Hill, Mrs. Wallace C.....248 S. Hawthorne
Holtzman, Mrs. Norman.....3322 Whitcomb
Hyde, Mrs. Carroll C.....1521 E. Colfax Ave.

J-K

Jankowski, Mrs. Ernest B.....2230 Ribourde
Johns, Mrs. N. C.....52605 Brooktrails Dr.
Kamm, Mrs. Bernard A.....125 W. Marion St.
Karn, Mrs. John W.....1535 Wall St.
Krueger, Mrs. John E.....620 E. Peashway
Kuhn, Mrs. Frederick L.....1215 S. Michigan St.

L

Lamb, Mrs. J. Leonard....1321 E. Wayne St., S.
Lane, Mrs. William H.....845 Park Ave.
Lang, Mrs. Joseph E.....505 Dixie Highway N.
Lawrence, Mrs. John O.....3102 Sunnymede Ave.
Lester, Mrs. Vern L.....3536 Springbrook Dr.
Levatin, Mrs. Bernard I.....1814 Churchill Dr.
Levkoff, Mrs. Abner H...1815 E. Jefferson Blvd.
Lionberger, Mrs. John R. 1419 E. Jefferson Blvd.
Liss, Mrs. Emanuel C.....1228 E. Jefferson Blvd.
Lockhart, Mrs. Philip B.....1611 Wayne St. E.

M

MacDonell, Mrs. E. H.....1341 E. Colfax
MacLeod, Mrs. John K.....930 Simmon Ct.
Macri, Mrs. Paul A.....2824 Beechwood Lane
Mahank, Mrs. Camiel C...1804 E. Jefferson Blvd.
Marquis, Mrs. Gordon.....329 Wakewa
Martinov, Mrs. William E.....1421 Wall St.
Mason, Mrs. Bernard A.....2719 Marine St.
Mauzy, Mrs. Merritt C.....1740 Hass Dr.
McCraley, Mrs. William J.....1737 Belmont Ave.
McMeel, Mrs. James.....1138 Whitehall Dr.
Metcalfe, Mrs. Grant E.....1209 E. Wayne St., N.
Miller, Mrs. Milo K.....1018 E. Oakside
Mott, Mrs. C. A.....2733 Lincoln Way West
Mueller, Mrs. Hilbert M...3525 Windingwood Dr.
Murphy, Mrs. Eugene C.....1411 Sunnymede Ave.
Myers, Mrs. Philip R.....1147 Cleveland Ave.

N-O

Neher, Mrs. John L.....17371 Cleveland Rd.
Nelson, Mrs. Raymond E.....1909 E. Madison St.
Olson, Mrs. Donald T.....1806 Cedar St.
Olson, Mrs. Kenneth L.....1228 E. Woodside Ave.
Oren, Mrs. William.....1149 E. Belmont

P

Pairitz, Mrs. Frank.....1436 Sunnymede Ave.
Parsons, Mrs. Robert.....1464 Ridgedale Rd.
Pascuzzi, Mrs. Chris A.....1930 Dorwood Dr.
Pauszek, Mrs. Thomas B.....916 Riverside Dr.
Petrass, Mrs. Andrew....22027 Liberty Highway
Phelps, Mrs. Stephen R.....1331 Sunnymede Ave.
Plain, Mrs. George.....17836 Ponader Dr.
Pyle, Mrs. H. Dale.....115 N. Sunnyside Ave.

R

Rigley, Mrs. Edward L.....1704 Ridgedale Rd.
Roberts, Mrs. Billy J.....1523 Crestwood Blvd.
Rosenheimer, Mrs. George M...1425 E. Woodside
Rubens, Mrs. Eli.....1240 E. Irvington

S

Sanderson, Mrs. Robert B...238 S. Hawthorne Dr.
Sandock, Mrs. Louis F.....235 S. Esther St.
Sandoz, Mrs. Harry H.....239 S. Hawthorne Dr.
Schaphorst, Mrs. Richard A...514 Lincoln Way E.
Schiller, Mrs. Herbert A.....1813 E. Cedar St.
Scott, Mrs. Frank M.....1220 E. Woodside
Selby, Mrs. Keith E.....1327 E. Wayne St., N.
Sellers, Mrs. Francis.....814 Oakridge Dr.
Sharp, Mrs. Merle C.....17780 Waxwing Lane
Shriner, Mrs. Richard.....53362 Juniper Rd.
Sisson, Mrs. Norvel D.....1614 Oak Park Dr.
Skillern, Mrs. Scott.....1553 Southbrook Dr.
Slominski, Mrs. Harry H.....1862 College St.
Staunton, Mrs. Henry A.....124 S. 34th St.
Stiver, Mrs. Dan D.....1127 E. Wayne St. N.
Stogdill, Mrs. William J.....520 N. Coquillard Dr.
Stratigos, Mrs. Joseph S.....527 N. Lafayette

T

Thompson, Mrs. John M.....1618 E. Cedar St.
Thornton, Mrs. M. J. R. R. #2, Miami Rd.
Tirman, Mrs. Wallace S.....1224 E. Wayne St., N.

V-W-Z

Van Fleit, Mrs. W. E.....1617 E. Cedar St.
Vurpillat, Mrs. F. J.....2102 E. Cedar St.
Ward, Mrs. James.....325 Wakewa
Weiss, Mrs. Eugene.....1605 E. Washington Ave.
White, Mrs. Donald G.....1721 E. Altgeld
Wilson, Mrs. James M.....1507 E. Wayne
Zeiger, Mrs. Irvin L.....1205 E. Irvington

SHELBY COUNTY

Nigh, Mrs. R. M.....Fairland
Davis, Mrs. John A.....Flat Rock

Shelbyville

Arata, Mrs. Lucian A.....327 W. Broadway
Dalton, Mrs. Wilson L.....1712 Culbertson
Deupree, Mrs. William D.....50 W. Mechanic St.
Gehres, Mrs. Robert W.....610 Shelby St.
Green, Mrs. William L.....416 Tailholt Lane
Inlow, Mrs. Herbert H.....212 N. Harrison St.
Inlow, Mrs. Paul M.....104 W. Washington St.
Inlow, Mrs. W. D.....Spring Hill Rd.
McFadden, Miss Marian.....28 W. Mechanic St.
McFadden, Mrs. Walter C.....28 W. Mechanic St.
Miller, Mrs. Richard C.....17 W. Mechanic St.
Moheban, Mrs. Joseph.....Spring Hill Rd.
Paz, Mrs. Luis.....526 E. McKay Rd.
Phares, Miss Frances.....408 S. Harrison
Richard, Mrs. Norman F.....541 Lockerbie Rd.
Scott, Mrs. V. Brown.....R. R. 2, N. Riley Hwy.
Silbert, Mrs. David B.....1100 Fairfield Dr.
Spindler, Mrs. Robert D.....165 W. Mechanic St.
Tindall, Mrs. William R.....616 S. Harrison
Tower, Mrs. James H., Jr...239 W. Washington St.
Whitcomb, Mrs. Roger F.....218 W. Broadway

STARKE COUNTY

Leinbach, Mrs. Earl R.....206 Davis, Hamlet
DeNaut, Mrs. James F.....201 E. Lake St., Knox
Henry, Mrs. Howard J.....R. R. 1, Knox
Ingwell, Mrs. Guy B.....402 E. Lake St., Knox
McClure, Mrs. Clark.....R. R. 1, Knox

TIPPECANOE COUNTY

Lafayette

Babb, Mrs. Forrest J.....2106 S. Ninth St.
Bayley, Mrs. William E. 303 S. Ninth St.
Bridge, Mrs. Barton C.....22 Thise Ct.
Buhrmester, Mrs. Harry C.....Freiberger Lane
Carpenter, Mrs. James B.....15 N. 25th St.
Dubois, Mrs. Ramon B.....519 Calvert Lane
Harter, Mrs. Eli B.....918 King St.
Jones, Mrs. David.....716 Okaklawn
Karberg, Mrs. Richard J.....1212 El Prado
Klepinger, Mrs. Harry E.....909 N. 21st St.
Landis, Mrs. C. Byron.....70 Collins Dr.
McAdams, Mrs. Hugh B.....2110 Birch Lane
McClelland, Mrs. Donald C...1021 Highland Ave.
McPherson, Mrs. Richard C.....1603 S. Fifth St.
Miller, Mrs. Albert J.....927 Highland Ave.
Neumann, Mrs. Kenneth O.....1410 S. 18th St.
Ratcliff, Mrs. Frank W.....1000 Wea Ave.
Riggs, Mrs. W. A.....2505 Robinwood Dr.
Sholty, Mrs. William M.....Shadeland Farm Rd.
Trout, Mrs. Carl J.....800 State St.
Van Reed, Mrs. Earl.....806 S. Ninth St.
Vermilya, Mrs. Robert W..R. R. 5, Cedar Bluff Rd.

West Lafayette

Beuerman, Mrs. Virgil A.....509 Emily St.
Bolin, Mrs. Robert C.....908 Windsor Dr.
Canganelli, Mrs. Vincent G.....108 Mohawk Lane
Davis, Mrs. Howard B.....833 Hillcrest Rd.
Elliott, Mrs. Paul W.....348 W. Stadium Dr.
Hughes, Mrs. Richard R.....908 Carrolton Blvd.
Johnson, Mrs. Lowell R.....1601 Woodland Dr.
Kuipers, Mrs. Fred M.....2225 Sacramento Ave.
Marsh, Mrs. George W.....2121 Happy Hollow Rd.
Marvel, Mrs. Howard R.....136 Arrowhead Dr.
McAdams, Mrs. Robert C. 625 Ridgewood Dr.
Mather, Mrs. Charles R.....1815 Ravina Rd.
Mather, Mrs. Robert L.....321 Leslie Ave.
Mount, Mrs. William M.....217 Pawnee Dr.
Russell, Mrs. Henry T.....1315 N. Grant
Spurlock, Mrs. F. H.....1625 Western Dr
Stahl, Mrs. Edward T.....324 Park Lane
VanDen Bosch, Mrs. W. R.....715 Princess Dr.
Waits, Mrs. Chester L.....622 Rose St.
Washburn, Mrs. Mary.....209 Forest Hill Dr.
Weller, Mrs. Wendell A.....105 Pawnee Dr.

Baker, Mrs. John R.....Heath Rd., Buck Creek
Weller, Mrs. Ralph.....Box 38, Rossville

VANDERBURGH COUNTY

Evansville

A

Acre, Mrs. Robert R.....2311 Lincoln Ave.
Adler, Mrs. Ray N.....1660 Lincoln Ave.
Adye, Mrs. Wallace M.....320 Inwood Dr.
Alexander, Mrs. John E.....7720 Lauderdale Dr.
Antes, Mrs. Earl H.....1201 Bonnie View Dr.
Arendell, Mrs. Robert E....710 S. Weinbach Ave.
Austin, Mrs. Eugene W...2163 Bayard Park Dr.

B

Baker, Mrs. Mason R.....4500 E. Cherry St.
Barnhart, Mrs. Willard T.....507 S. Boeke Rd.
Bebout, Mrs. Donald E.....814 Rotherwood Ave.
Beck, Mrs. Robert E.....6000 Newburgh Rd.
Beisel, Mrs. Larry H.....1427 Lark
Bender, Mrs. Martin J.....2416 Bayard Park Dr.
Bennett, Mrs. Abner P.....961 Blue Ridge Rd.
Bissonette, Mrs. Roger P.....911 Colony Rd.
Bloss, Mrs. Bryant A.....8006 Heather Court
Boone, Mrs. Robert D.....417 S. Alvord Blvd.
Brakel, Mrs. Frank, Jr.....1429 Oriole Dr.
Britt, Mrs. Robert L.....6317 Newburgh Rd.
Brockmole, Mrs. Arnold W.
5901 New Harmony Rd.
Brown, Mrs. George W.....757 S. Lombard
Bryan, Mrs. Stanton L.....3211 E. Mulberry St.
Buehner, Mrs. Donald F.....1200 Bonnie View Dr.
Burger, Mrs. Thomas C.....3915 Washington Ave.
Burnikel, Mrs. Ray H.....960 S. Rotherwood Ave.
Burress, Mrs. Clyde.....10100 Old St. Rd.

C

Cacia, Mrs. John J.....420 S. Boeke Rd.
Carlson, Mrs. Ralph F.....1350 Bayard Park Dr.
Clark, Mrs. Thomas W.....820 S. Meadow Rd.
Clouse, Mrs. Paul A.....5801 Newburgh Rd.
Coleman, Mrs. Joseph E.....2831 Wayside Dr.
Colvin, Mrs. Robert.....2048 Polaris
Cooper, Mrs. Waller W.....4410 Oak St.
Corcoran, Mrs. P. J. V.....2412 E. Chandler Ave.
Crawford, Mrs. James.....631 Blue Ridge Dr. W.
Crevello, Mrs. Albert J.....1664 Lincoln Ave.
Cullnane, Mrs. Chris W.....3020 Mt. Vernon Ave.
Cymbala, Mrs. Bohdan.....R. R. 8, Box 428

D

Daves, Mrs. W. Lawrence.....708 College Hwy.
Davidson, Mrs. Harold H.....800 Blue Ridge Rd.
Davis, Mrs. Max D.....1426 Lark
Deems, Mrs. Myers.....6830 Arcadian Highway
Denzer, Mrs. Edward K.....540 Scenic Dr.
Denzer, Mrs. William O.....923 Bellemeade
Dieckman, Mrs. Herbert S.....10 Johnson Place
Dodd, Mrs. R. K.....1705 S. New Green River Rd.
Durkee, Mrs. Melvin S.....615 Trinity Dr.
Durkin, Mrs. John W., Jr.....2524 Adams St.
Dycus, Mrs. Walter A.....3400 Koring Rd.
Dyer, Mrs. Wallace K.....812 St. James Blvd.

E

Ebin, Mrs. J. L.....1508 Southfield Rd.
Engel, Mrs. Edgar L.....1411 E. Park Dr.
Ewer, Mrs. Robert W.....7226 E. Blackford

F

Faith, Mrs. Ira L.....950 Blue Ridge Rd.
Faul, Mrs. Henry J.....725 S. Willow Rd.
Faw, Mrs. Melvin L.....2400 E. Chandler
Fenneman, Mrs. Robert J.
Box 145, R. R. 8, Old St. Rd.
Fisher, Mrs. William C.....1319 S. Kentucky
Fitzsimmons, Mrs. Elvin L.....500 S. Boeke Rd.

G

Garland, Mrs. Edgar A.....719 Plaza Dr.
Garst, Mrs. Garland.....1928 Theatre Dr.
Gaul, Mrs. L. Edward.....18 Johnson Pl.
Geller, Mrs. Samuel.....R. R. 8, Box 143-A
Getty, Mrs. William H.....1810 Mt. Auburn Rd.
Giorgio, Mrs. Douglas J.....916 S. Burkhart Rd.
Gourieux, Mrs. E. DeVerre....1019 S. Vann Ave.
Griep, Mrs. Arthur H.....5414 Madison Ave.
Grimm, Mrs. William C...513 S. Rotherwood Ave.

H

Hammond, Mrs. R. Case.....6820 Arcadian Hwy.
Hare, Mrs. Daniel M.....5029 Lincoln Ave.
Harlan, Mrs. William L.....731 S. Frederick
Harned, Mrs. Ben King, Jr.....8232 Maple Lane
Harris, Mrs. Robert L.....4 Woodmere Lane
Hart, Mrs. L. Paul.....622 Trinity Dr.
Hartley, Mrs. Clarence A., Jr.....300 Hesmer Rd.
Hassel, Mrs. Walter.....732 E. Maryland
Heinrich, Mrs. Weston A.....1408 Lincoln Ave.
Hendershot, Mrs. Eugene L...7006 Newburgh Rd.
Hermayer, Mrs. Stephen....1316 Bonnie View Dr.
Herrmann, Mrs. Gordon T.....218 S. Spring St.
Herzer, Mrs. Clarence C.....211 E. Mill Rd.
Himebaugh, Mrs. Gilbert J.....408 S. Alvord Blvd.
Hobgood, Mrs. James L.....6400 Jefferson
Hoover, Mrs. J. Guy.....864 Lodge Ave.
Hovda, Mrs. Richard B.....800 St. James Blvd.
Huggins, Mrs. Victor S.....520 S. Alvord Blvd.
Hyatt, Mrs. Gilbert T.....1616 Mt. Auburn Rd.

J-K

Johnson, Mrs. Stephen L.....2215 Lincoln Ave.
Johnson, Mrs. Harold V.....1303 Masker Pk. Dr.
Kelley, Mrs. John B.....1420 Lark Dr.
Kiechle, Mrs. Fred L.....726 S. E. First St.
Kimmel, Mrs. George....200 S. Lincoln Park Dr.
Kincaid, Mrs. Robert S.....5417 Stringtown Rd.

L

Laubscher, Mrs. Clarence A...1201 Laubscher Rd.
Lawrence, Mrs. Joseph C. 1362 E. Chandler Ave.
Liebundguth, Mrs. Henry.....5206 Lincoln Ave.
Lessure, Mrs. Alfred P.....3109 E. Oak St.
Lewis, Mrs. Earl T.....550 S. Ruston Ave.
Logan, Mrs. Jesse R.....503 First Ave.

M

MacKenzie, Mrs. Pierce.....2300 E. Gum St.
Marvel, Mrs. James A.....1431 Green Meadow
Mathews, Mrs. James R.....901 Meadow Rd.
Maxson, Mrs. Roy V.....763 S. Weinbach Ave.
McCool, Mrs. Joe H.....#1 Woodmere Lane
McDonald, Mrs. Joseph D.....4300 Lincoln Ave.
Miller, Mrs. LaVerne B.....501 Scenic Dr.
Miller, Mrs. Milton J.....8201 Newburgh Rd.
Mills, Mrs. Fred E.....555 S. Kelsey Ave.
Mino, Mrs. Robert A.....2808 N. Shore Dr.
Moehlenkamp, Mrs. Charles E.
5401 Stringtown Rd.

N

Newnum, Mrs. Raymond L.....727 College Hwy.
Nicholson, Mrs. Raymond W...1467 Southfield Rd.
Niedermayer, Mrs. Alfred J.....815 College Hwy.
Nonte, Mrs. Leo R.....714 S. Willow Rd.
Noveroske, Mrs. Richard.....3204 Stratford Rd.

O

Oswald, Mrs. Robert H.....2423 Lincoln Ave.

P

Pastor, Mrs. Julius W.....5901 Washington Ave.
Pavlick, Mrs. Theodore J.....4212 Jennings Lane
Pemberton, Mrs. Jack J.....Falstead Rd., R. R. 1
Pollard, Mrs. Walter S.....1230 S. E. Second St.
Porro, Mrs. Francis W.....909 S. Villa Dr.
Present, Mrs. Julian D.....201 S. Parker Dr.
Pugh, Mrs. Willis L.....5204 Lincoln Ave.

R

Radcliff, Mrs. Forest F., Jr.....1154 S. Villa Dr.
Ratcliffe, Mrs. Albert W.....510 S. E. First St.
Reich, Mrs. Clarence E.....1209 N. Fulton Ave.
Richey, Mrs. Clifford O.....407 Congress Ave.
Rietman, Mrs. H. Jerome.....2325 Lincoln Ave.
Rininger, Mrs. Harold C.....2154 E. Gum St.
Ritchie, Mrs. William D.....5201 Stringtown Rd.
Ritz, Mrs. Albert S.....765 S. Boeke Rd.
Rosenblatt, Mrs. Bernard B...626 St. James Blvd.
Royster, Mrs. Robert A.....34 Johnson Place
Ruddick, Mrs. Hobart.....Regina Pacis Home
Rudolph, Mrs. Kenneth.....742 Plaza Dr.
Rupper, Mrs. Warren R.
Heckle Rd., Box 159, R. R. 3
Russell, Mrs. Richard H.....1015 Harrelton Ct.

S

Schimmelpfennig, Mrs. Robert W.
3014 Washington Ave.
Schirmer, Mrs. Robert H.....2710 Hartmetz Ave.
Schneider, Mrs. Charles P...2924 W. Maryland St.
Sheehan, Mrs. E. Gregg.....934 York Rd.
Sinn, Mrs. Charles M.....1509 Redwing Dr.
Slaughter, Mrs. Howard C.....651 St. Mary's Dr.
Slaughter, Mrs. John C.....622 College Hwy.
Slaughter, Mrs. Owen L.....506 St. James Blvd. S.
Smith, Mrs. Roy M.....417 Senate
Spain, Mrs. Thomas.....400 Runnymeade Ave.
Sprecher, Mrs. Herman C.....6601 Newburgh Road
Springstun, Mrs. W. Russel.....854 Lodge Ave.
Stallings, Mrs. Hugh A.....7601 Newburgh Rd.
Steele, Mrs. Paul W.....1906 Bellemeade Ave.
Sterne, Mrs. John H.....2308 E. Gum St.
Stewart, Mrs. L. Ray.....856 S. Alvord Blvd.
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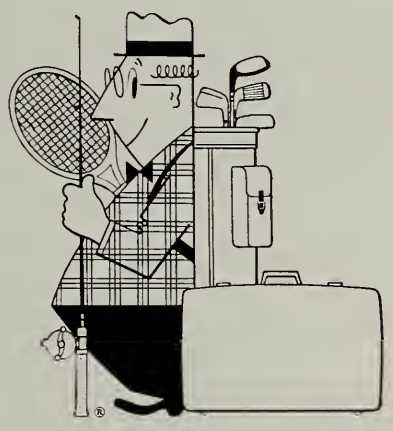


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1964 Walter Kennedy, M.D., 208 Union Block, New Castle (representing New Castle State Hospital Advisory Committee)

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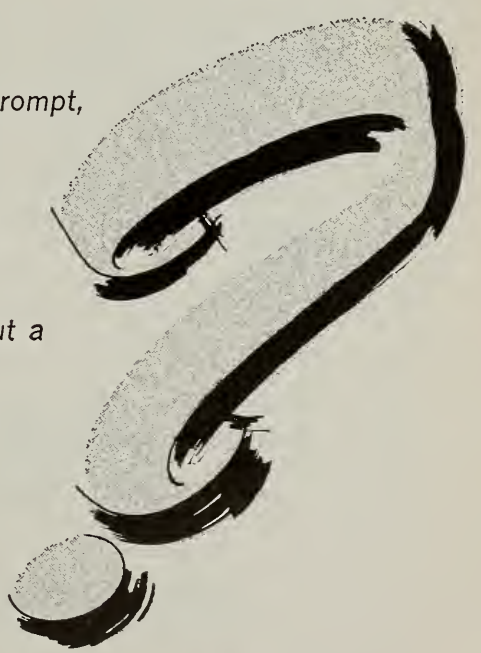
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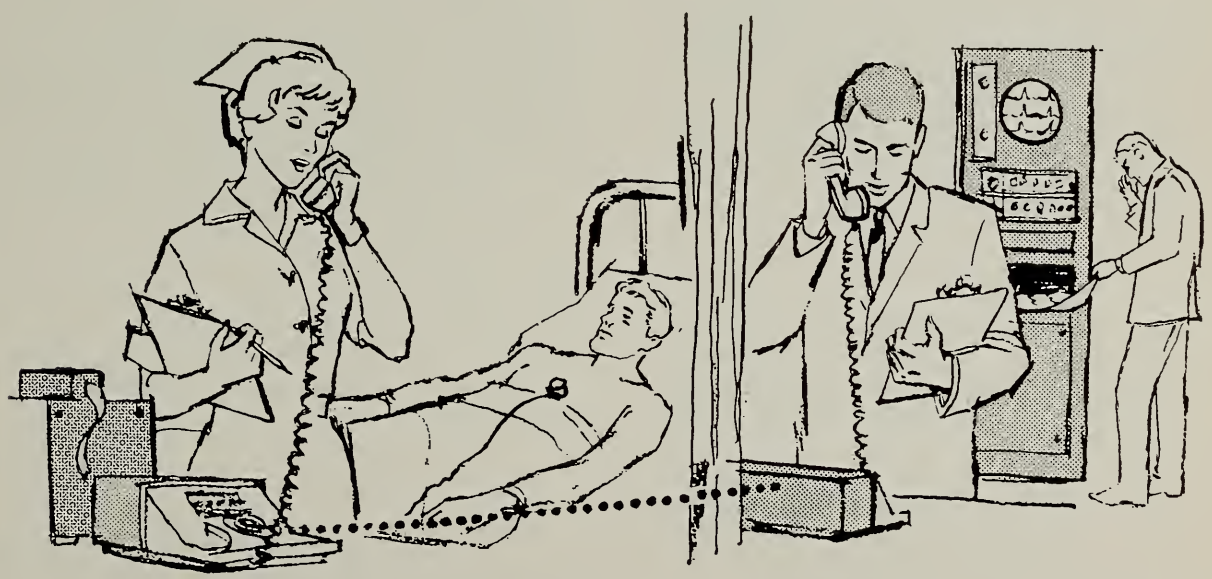
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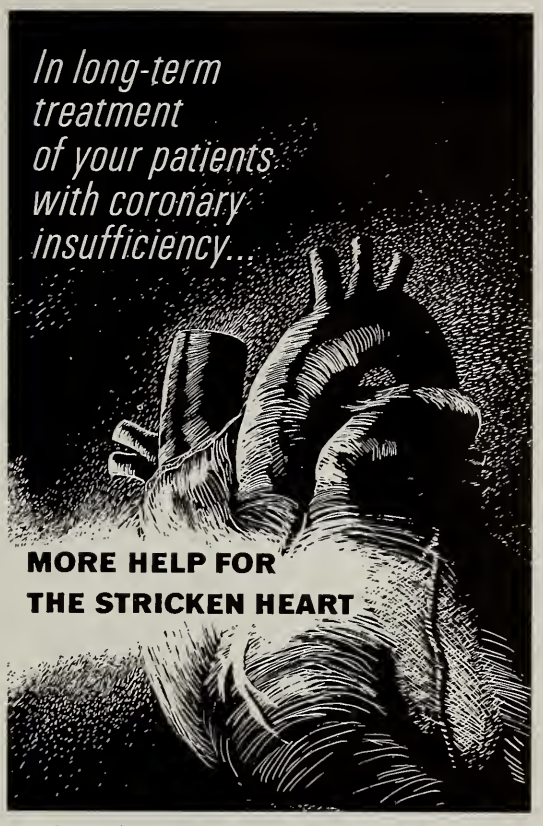
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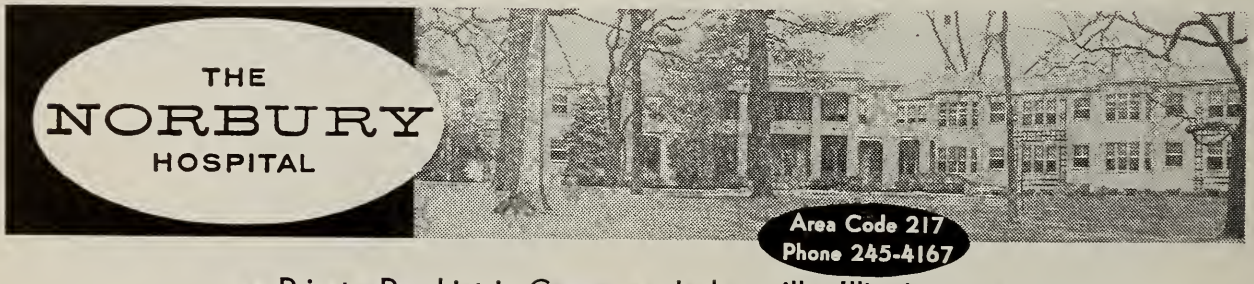
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*This one at Olympic National Park, Washington.

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Due to the additional content of the Yearbook, cutt-off date for changes in the following groups was in April. Some have changed in the interim. However, it is felt that where officers have changed, a query to those listed here will put interested persons in contact with such groups.

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Department of Public Health—Samuel H. Hopper, Ph.D., Indianapolis.

Department of Pathology—Parker R. Beamer, M.D., Indianapolis.

Department of Microbiology—Edward W. Shrigley, M.D., Ph.D., Indianapolis.

Department of Orthopedic Surgery—George Garceau, M.D., Indianapolis.

Department of Surgery—Harris B Shumacker, Jr., M.D., Indianapolis.

Department of Medicine—John B. Hickam, M.D., Indianapolis.

Department of Neurology—Alexander T. Ross, M.D., Indianapolis.

Department of Psychiatry—John I. Nurnberger, M.D., Indianapolis.

Department of Radiology—John A. Campbell, M.D. Indianapolis.

Department of Obstetrics and Gynecology—Carl P. Huber, M.D., Indianapolis.

Department of Otorhinolaryngology and Bronchoesophagology—David E. Brown, M.D., Indianapolis.

Department of Ophthalmology—Fred M. Wilson, M.D., Indianapolis.

Department of Urology—Robert A. Garrett, M.D., Indianapolis.

Department of Pharmacology—James E. Ashmore, Ph.D., Indianapolis.

Department of Pediatrics—Lyman T. Meiks, M.D., Indianapolis.

Department of Anesthesiology—Vergil K. Stoelting, M.D., Indianapolis.

Department of Dermatology—Victor C. Hackney, M.D., Indianapolis.

INDIANA UNIVERSITY MEDICAL CENTER
1100 W. Michigan Street
Indianapolis

Administrator—Mr. Edmund J. Shea.
Medical Director—W. D. Close, M.D.
Director of Clinical Laboratories—J. L. Arbogast, M.D.
Chief Radiologist—J. A. Campbell, M.D. ◄

INDIANA STATE BOARD OF HEALTH

MONTHLY REPORT — April, 1964

Disease	Apr. 1964	Mar. 1964	Feb. 1964	Apr. 1963	Apr. 1962
Animal Bites	904	427	396	890	785
Chickenpox	723	835	608	658	468
Conjunctivitis	207	151	139	87	97
Diphtheria	0	0	0	0	2
Dysentery, Unspecified	71	61	204	60	34
Gonorrhea	312	279	333	Not Available	
Impetigo	146	134	130	64	81
Infectious Hepatitis	71	53	46	52	212
Infectious Mononucleosis	97	41	62	23	32
Influenza	506	818	1060	959	750
Measles (Rubeola-Rubella)	6868	4541	2054	1176	1723
Meningitis, Meningococcal	9	8	5	3	5
Meningitis, Other	9	5	7	9	6
Mumps	1422	1047	843	370	450
Pertussis	53	26	16	13	26
Pneumonia	344	157	226	197	124
Poliomyelitis	0	0	0	0	0
Streptococcal Infections	903	766	647	582	530
Syphilis					
Primary & Secondary	6	3	3	Not Available	
All Other Syphilis	105	101	103	Not Available	
Tinea Capitis	27	20	21	2	8
Tuberculosis (Active)	169	114	78	161	78

ROSTER AND YEARBOOK ISSUES

This is the Roster and Yearbook issue of the Indiana State Medical Association. Included in the Roster are the names of all members of the ISMA listed alphabetically and by counties, plus the names of all the Woman's Auxiliary.

The Yearbook, besides carrying the Roster, includes listings of the following: State Health Organizations; Professional Medical and Allied Organizations; Voluntary Organizations; Heads of Departments at the I. U. School of Medicine; Indiana Accredited Practical Nursing Schools; Approved Hospitals in Indiana; Approved Mental Hospitals; Licensed Nursing Homes; Poison Control Centers in Indiana; Disease Prevention by Immunization and Chemoprophylaxis and Class A Narcotic Drugs.

If you would like to order either or both of these special issues, please check the appropriate box and send it along with your check or money order to *The Journal*, 3935 N. Meridian St., Indianapolis 8.

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de effects: Although there has been no evidence of tolerance, thdrawal symptoms or excessive self-medication, 'Soma' mpound and 'Soma' Compound with Codeine, like other ntral nervous system depressants, should be used with cau- n in addiction-prone individuals. While codeine addiction is atively rare and easily broken, the same precautions must be served as for any other opium alkaloid. Nausea, vomiting, nstipation and miosis are possible codeine side effects. Should mptoms of hypersensitivity occur, discontinue medication.

Contraindications: None reported.

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CSO-1054

Approved Hospitals in Indiana*

April 1, 1964

ADAMS COUNTY

Adams County Memorial Hospital.
804 Mercer Ave., Decatur.
Mr. Thurman I. Drew, Adm.

ALLEN COUNTY

Parkview Memorial Hospital, Inc.
2200 Randalia Dr., Fort Wayne.
Mr. Mark Slen, Adm.

Irene Byron Hospital
12515 Lima Rd., R.R. 13, Fort Wayne
O. T. Kidder, M.D., Adm. & Med. Dir.

The Lutheran Hospital of Fort Wayne.
3024 Fairfield Ave, Fort Wayne.
Mr. Edgar C. Kruse, Adm.

St. Joseph's Hospital.
730 W. Berry St., Fort Wayne.
Sister M. Odillia, Adm.

BARTHOLOMEW COUNTY

Bartholomew County Hospital.
2400 East 17th St., Columbus.
Miss Olive M. Murphy, R.N., Adm.

BLACKFORD COUNTY

Blackford County Hospital.
503 E. Van Cleve St., Hartford City.
Mrs. Mabel Brown, Adm.

BOONE COUNTY

Witham Memorial Hospital.
1124 N. Lebanon St., Lebanon.
Mr. John H. Luff, Adm.

CASS COUNTY

Memorial Hospital.
1101-1115 Michigan Ave., Logansport.
Mr. Herbert L. Fromm, Adm.

St. Joseph Hospital.
26th and North Sts., Logansport.
Sister M. Laurine, Adm.

CLARK COUNTY

Clark County Memorial Hospital.
210 Sparks Ave., Jeffersonville.
Mr. Robert D. Shaffer, Adm.

CLAY COUNTY

Clay County Hospital.
1206 E. National Ave., Brazil.
Mr. Karl J. Dickerson, Adm.

CLINTON COUNTY

Clinton County Hospital.
1300 S. Jackson St., Frankfort
Mr. William Russell, Adm.

DAVIESS COUNTY

Daviess County Hospital.
1310 Grand Ave., Washington.
Mr. Lawrence Trousdale, Adm.

DEARBORN COUNTY

Dearborn County Hospital.
600 Wilson Creek Rd., Lawrenceburg
Mr. John H. Tallmadge, Adm.

DECATUR COUNTY

Decatur County Memorial Hospital.
720 N. Lincoln St., Greensburg.
Mr. William D. Gibson, Adm.

DEKALB COUNTY

DeKalb Memorial Hospital, Inc.
East Seventh St., Auburn.
Mr. R. O. King, Adm.

Dr. Bonnell M. Souder Hospital, Inc.
206 W. 7th St., Auburn.
Bonnell M. Souder, M.D., Adm.

Garrett Community Hospital, Inc.
220 S. Ijams St., Garrett.
Mr. Carl F. Arntson, Adm.

DELAWARE COUNTY

Ball Memorial Hospital.
2401 University Ave., Muncie.
Mr. Walter G. Ebert, Adm.

DUBOIS COUNTY

Memorial Hospital of Dubois County.
800 West 9th St., Jasper.
Mother M. Eugene, Adm.

The Stork Memorial Hospital.
530 4th St., Huntingburg.
Sister Josepha, Adm.

ELKHART COUNTY

Elkhart General Hospital.
600 East Boulevard, Elkhart.
Mr. Emery K. Zimmerman, Adm.

Goshen General Hospital.
200 High Park Avenue, Goshen.
Mr. W. J. Dye, Adm.

FAYETTE COUNTY

Fayette Memorial Hospital.
1941 Virginia Ave., Connersville.
Mr. Richards M. Manuel, Adm.

FLOYD COUNTY

Memorial Hospital of Floyd County.
1850 State St., New Albany.
Mr. William I. Fender, Jr., Adm.

Southern Indiana Tuberculosis Hospital.
New Albany.
Joseph H. Geyer, M.D., Adm.

FULTON COUNTY

Woodlawn Hospital.
624 Pontiac St., Rochester.
Mr. Edward Kucinski, Adm.

GIBSON COUNTY

Gibson General Hospital.
Sherman Drive, Princeton.
Mr. Herman A. Kohlman, Adm.

* Approved by the Indiana Council for Hospital Licensure and the Indiana State Board of Health.

GRANT COUNTY

Marion General Hospital.
Wabash and Euclid, Marion.
Mr. John W. Green, Adm.

GREENE COUNTY

Freeman Greene County Hospital.
410 "A" St., N.E., Linton.
Mr. Avery Murray, Adm.

HAMILTON COUNTY

Riverview Hospital.
R.R. 4, Noblesville
Mr. John Keilholz, Adm.

HANCOCK COUNTY

Hancock County Memorial Hospital.
800 North State Street, Greenfield.
Mr. C. L. Morris, Adm.

HARRISON COUNTY

Harrison County Hospital.
R. R. 4, Box 33 H, Corydon.
Mr. John R. Webb, Adm.

HENDRICKS COUNTY

Hendricks County Hospital.
1000 E. Main St., Danville.
Mr. Harry T. Haver, Jr., Adm.

HENRY COUNTY

Henry County Hospital.
Rural St., New Castle.
Mr. Herbert A. Schacht, Adm.

The Clinic.
1319 Church St., New Castle.
Kenneth G. Hill, M.D., Adm.

HOWARD COUNTY

Howard Community Hospital.
3500 S. LaFountain St., Kokomo.
Mr. Barry T. Bedenkop, Adm.

St. Joseph Memorial Hospital.
1907 W. Sycamore St., Kokomo.
Sister Ann Rita, Adm.

HUNGTINGTON COUNTY

Huntington County Hospital.
1215 Etna Ave., Huntington.
Mr. Carl S. Smyth, Adm.

JACKSON COUNTY

Jackson County Schneck Memorial Hospital.
Bruce and Poplar St., Seymour.
Mr. Ralph W. Keyes, Adm.

JASPER COUNTY

Jasper County Hospital.
216-224 S. Cullen St., Rensselaer.
Mrs. Ruth Schumaker, R.N., Adm.

JAY COUNTY

Jay County Hospital.
505 W. Arch St., Portland.
Mr. Warren Phemister, Adm.

JEFFERSON COUNTY

The King's Daughters' Hospital.
112 Presbyterian Ave., Madison.
Mr. W. A. McAlexander, Adm.

JOHNSON COUNTY

Indiana Masonic Home Hospital.
690 State St., Franklin.
Mr. Roy Turner, Jr., Supt.

Johnson County Memorial Hospital.
R.R. 1, Franklin.
Mr. George P. Goshorn, Adm.

KNOX COUNTY

Good Samaritan Hospital.
410 S. 7th St., Vincennes.
Mr. Stephen Collins, Adm.

Hillcrest Tuberculosis Hospital.
North 2nd St. Road, Vincennes.
J. Frank W. Stewart, M.D., Adm.

KOSCIUSKO COUNTY

Murphy Medical Center.
101 W. Winona Ave., Warsaw.
Mrs. Hazel J. Murphy, Adm.

LAGRANGE COUNTY

LaGrange County Hospital.
R.R. 1, LaGrange.
Miss Edythe L. Gappinger, R.N., Adm.

LAKE COUNTY

James O. Parramore Hospital.
106 Road O, Crown Point.
Phillip H. Becker, M.D., Adm.

The Methodist Hospital of Gary, Inc.
1600 W. 6th Ave., Gary.
Mr. Everett A. Johnson, Adm.

Our Lady of Mercy Hospital.
U. S. Highway 30, Dyer.
Sister Mary Pierre, Adm.

St. Catherine Hospital.
4321 Fir St., East Chicago.
Sister M. Martine, Adm.

St. Margaret Hospital.
25 Douglas St., Hammond.
Sister M. Delphina, R.N., Adm.

St. Mary Mercy Hospital.
540 Tyler St., Gary.
Sister M. Cornelia, R.N., Adm.

LAPORTE COUNTY

Community Hospital of LaPorte, Inc.
215 Pine Lake Ave., LaPorte.
Mr. L. H. Furlong, Adm.

Holy Family Hospital.
205 "E" St., LaPorte.
Sister M. Justine, Adm.

Memorial Hospital of Michigan City Foundation, Inc.
125 E. 5th St., Michigan City.
Mr. Byron N. Whitford, Dir. of Hospital.

St. Anthony Hospital.
Wabash and Ann Sts., Michigan City.
Sister M. Regis, Adm.

Walters Hospital, Inc.
719 Franklin St., Michigan City.
Mr. Robert Keller, Adm.

Continued

APPROVED HOSPITALS

Continued

LAWRENCE COUNTY

Dunn Memorial Hospital.
1616 23rd St., Bedford.
Mrs. Helen Boyer, R.N., Adm.

MADISON COUNTY

Community Hospital of Anderson and Madison County.
1515 N. Madison Ave., Anderson.
Mr. Gordon S. Boughton, Adm.

Mercy Hospital, Inc.
1331 South "A" St., Elwood.
Sister M. Andrea, R.N., Adm.

St. John's Hickey Memorial Hospital.
127 W. 19th St., Anderson.
Sister Mary, Adm.

MARION COUNTY

Community Hospital of Indianapolis, Inc.
1500 N. Ritter Ave., Indianapolis.
Mr. W. C. McLin, Adm.

Indiana University Medical Center Hospitals.
1100 W. Michigan St., Indianapolis.
Mr. Edmund J. Shea, Adm.

Marion County General Hospital.
960 Locke St., Indianapolis.
Arvine G. Popplewell, M.D., Supt. and Dir. of Hosp.

Marion County Tuberculosis Hospital.
Sunnyside Sanitorium, 6255 Sunnyside Road, Indianapolis.
John D. Miller, M.D., Adm. & Med. Dir.

Memorial Clinic of Indianapolis.
3202 N. Meridian St., Indianapolis.
Mr. Richard L. Albright, Adm.

Methodist Hospital of Indiana, Inc.
1604 N. Capitol Ave., Indianapolis.
Mr. Jack A. L. Hahn, Adm.

St. Elizabeth's Maternity Hospital and Infant Home.
2500 Churchman Ave., Indianapolis.
Rev. Donald Schmidlin, Adm.

St. Francis Hospital.
N. 17th St. and Sherman Dr., Beech Grove.
Sister Vincentiana, Adm.

St. Vincent's Hospital.
120 W. Fall Creek Parkway, Indianapolis.
Sister Mary Helen, Adm.

University Heights Hospital, Inc.
3350 Carson Ave., Indianapolis.
Mr. Donald L. Ciolli, Adm.

MARSHALL COUNTY

Community Hospital of German Township, Inc.
411 W. Grant St., Bremen.
Mrs. Mary Harris, R.N., Adm.

Parkview Hospital.
1401 N. Michigan St., Plymouth.
Miss Lela Diefenbaugh, R.N., Adm.

MIAMI COUNTY

Dukes Memorial Hospital.
275 West 12th St., Peru.
Mr. Jack G. Fougerousse, Adm.

Wabash Employes' Hospital Association.
425 N. Broadway, Peru.
Mr. William R. Milnes, Supt.
360 East Grand Ave., Decatur, Ill.

MONROE COUNTY

Bloomington Hospital.
640 S. Rogers St., Bloomington.
Mr. John H. Shephard, Adm.

MONTGOMERY COUNTY

Montgomery County Culver Union Hospital.
308 Binford St., Crawfordsville.
Mr. Wm. R. Saunders, Adm.

MORGAN COUNTY

Comer-Kendrick Hospital, Inc.
130 N. Indiana St., Mooresville.
William Kendrick, M.D., Adm.

Morgan County Memorial Hospital.
St. Rd. 252, Martinsville.
Mr. Ernest Baughman, Adm.

NEWTON COUNTY

George Ade Memorial Hospital.
Brook, Ind.
Mr. Darryl Wahler, Adm.

NOBLE COUNTY

McCray Memorial Hospital.
Hospital Dr., Kendallville.
Mr. Ronald N. Strand, Adm.

ORANGE COUNTY

Orange County Hospital.
Sandy Hook Road, Paoli.

PARKE COUNTY

Indiana State Hospital for Chest Diseases.
R.R. 1, Rockville.
William D. May, M.D., Supt.

PERRY COUNTY

Perry County Memorial Hospital.
Star Route, Tell City.
Mr. David Alien, Adm.

PORTER COUNTY

Porter Memorial Hospital.
814 LaPorte Ave., Valparaiso.
Mr. Arthur S. Malasto, Adm.

PULASKI COUNTY

Pulaski Memorial Hospital.
State Road 14, East, Winamac.
Mr. Benjamin L. Underwood, Adm.

PUTNAM COUNTY

Putnam County Hospital.
330 Greenwood Ave., Greencastle.
Mr. James F. Shepherd, Adm.

RANDOLPH COUNTY

Randolph County Hospital.
Oak Street, Winchester.
Mr. Harvey Norris, Adm.

Union City Memorial Hospital Association.
900 N. Columbia St., Union City.
Miss Kathryn E. Larrance, Adm.

RIPLEY COUNTY

Margaret Mary Hospital.
Rosemont Division, Batesville.
Sister M. Theresa, Adm.

RUSH COUNTY

Rush Memorial Hospital.
1300 N. Main St., Rushville.
Miss Nina Bosso, R.N., Adm.

SCOTT COUNTY

Scott County Memorial Hospital.
Highway 31 North, Scottsburg.
Mr. James K. Fisler, Adm.

SHELBY COUNTY

William S. Major Hospital.
150 W. Washington St., Shelbyville.
Mr. Roland E. Kohr, Adm.

ST. JOSEPH COUNTY

Healthwin Hospital.
20531 West Darden Road, South Bend.
E. W. Custer, M.D., Adm.

Memorial Hospital of South Bend.
615 N. Michigan St., South Bend.
Mr. Richard W. Trenkner, Adm.

St. Joseph Hospital.
215 W. 4th St., Mishawaka.
Sister M. Maureen, Adm.

St. Joseph Hospital of South Bend.
811 E. Madison St., South Bend.
Sister M. Michaeleen, Adm.

South Bend Osteopathic Hospital.
2515 E. Jefferson Blvd., South Bend.
A. F. Kull, D.O., Adm.

STARKE COUNTY

Little Company of Mary Hospital and Home for Chronically Ill, Inc.
Route 421, San Pierre.
Mother M. Catherine, Adm.

Starke Memorial Hospital.
102 Culver Road, Knox.
Mr. Lynn L. Landis, Adm.

STEUBEN COUNTY

Cameron Memorial Hospitals, Inc.
416 E. Maumee, Angola.
Mrs. Harriet Angus, R.N., Adm.

Elmhurst Hospital, Inc.
909 W. Maumee, Angola.
Mr. T. Ray Alwood, Adm.

SULLIVAN COUNTY

Mary Sherman Hospital.
320 N. Section St., Sullivan.
Mr. William H. Sluder, Adm.

TIPPECANOE COUNTY

Indiana State Soldiers' Home Hospital.
State Road 43 North, Lafayette.
Col. Harold A. Shindler, Commandant, Adm.

Lafayette Home Hospital, Inc.
2400 E. South St., Lafayette.
Mr. Franklin E. Simek, Adm.

St. Elizabeth Hospital.
1501 Hartford Street, Lafayette.
Sister M. Amelia, R.N., Adm.

TIPTON COUNTY

Tipton County Memorial Hospital.
1032 South Main Street, Tipton.
Mr. James C. Talley, Adm.

VANDERBURGH COUNTY

Boehne Tuberculosis Hospital.
Boehne Hospital Rd., Station B., Evansville.
Mr. J. E. Janzen, Adm.

Protestant Deaconess Hospital.
600-700 Mary St., Evansville.
Albert G. Hahn, L.H.D., Adm.

St. Mary's Hospital, Inc.
3700 Washington Ave., Evansville.
Sister Mary James, Adm.

Welborn Memorial Baptist Hospital, Inc.
412 S.E. 4th St., Evansville.
Mr. Nolan R. Lackey, Adm.

VERMILLION COUNTY

Vermillion County Hospital.
800 S. Main St., Clinton.
Miss Beulah Fisher, R.N., Adm.

VIGO COUNTY

St. Anthony Hospital.
1021 S. 6th St., Terre Haute.
Sister M. Athanasia, Adm.

Union Hospital, Inc.
1606 N. 7th St., Terre Haute.
Miss Ellen E. Church, R.N., Adm.

WABASH COUNTY

Wabash County Hospital.
670 N. East St., Wabash.
Mr. Richard G. Shedd, Adm.

WARREN COUNTY

Community Hospital.
412 N. Monroe St., Williamsport.
Mr. George H. James, Jr., Adm.

WASHINGTON COUNTY

Washington County Memorial Hospital.
N. Shelby Street, Salem.
Mr. Harry M. Voyles, Adm.

WAYNE COUNTY

Reid Memorial Hospital.
Spring Grove, Richmond.
Mr. G. Dale Splitstone, Adm.

WELLS COUNTY

Clinic Hospital.
309 S. Main St., Bluffton.
Mr. Ronald M. Adams, Adm.

Wells County Hospital.
1116 S. Main St., Bluffton.
Mrs. Dorothy Elett Radkey, R.N., Adm.

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APPROVED HOSPITALS

Continued

WHITE COUNTY

White County Memorial Hospital.
Monticello
Mr. George R. Banjak, Adm.

WHITLEY COUNTY

Memorial Hospital.
215 E. Van Buren St., Columbia City.
Mr. Carl F. Arntson, Adm.

Whitley County Memorial Hospital.
353 N. Oak St., Columbia City.
Mr. Stanley S. Mullendore, Adm.

Approved Mental Hospitals in Indiana

See State-Operated Mental Institutions, Page 638.

Clearview Hospital.
Kratzville Road, Evansville
Mr. William J. Bulger, Adm.

Ann Taylor Hospital.
2231 Broadway, Indianapolis.
Mrs. Ann Long, Mrs. May Masters, Adms.

Wabash Valley Sanitarium.
Lafayette.
Mr. Donald R. Kinzer, Bus. Mgr. ◄





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Licensed Nursing Homes In Indiana

January, 1964

ADAMS COUNTY

Berne Nursing Home
906 W. Main St., Berne
Pauline Hostetler, L.P.N., Adm.

ALLEN COUNTY

Crow's Haven
2440 Bowser Ave., Fort Wayne
Lyle Crow, Adm.

East Creighton Nursing Home
927 E. Creighton St., Ft. Wayne
Mary M. Poindexter, Adm.

Fairfield Convalescent Home
2520 Fairfield Ave., Ft. Wayne
John R. and Beatrice M. Morse, Adms.

Glenacres, Inc.
3420 E. State St., Fort Wayne
Ruby J. Setser, Adm.

Grace Convalescent Home
1529 California Ave., Ft. Wayne
Emma L. Meyer, Adm.

Hope Manor
611 W. Wayne St., Fort Wayne
Charles W. and Ruby J. Setser, Adms.

Lawton Nursing Home, Inc.
1649 Spy Run Ave., Fort Wayne
Walter C. Buuck, L.P.N., Adm.

Twin Maples Sanitarium
734 W. Washington Blvd., Fort Wayne
Laszlo and Elizabeth Szegedy, Adms.

West Berry Rest Home
903 W. Berry, Fort Wayne
Charles W. and Ruby J. Setser, Adms.

BARTHOLOMEW COUNTY

Golden Age Retirement Center
R. R. 4, Shady Lane Rd., Columbus
Thelma Sharp, Adm.

Luther Nursing Home
837 Fourth St., Columbus
Mary Luther, Adm.

Mil-Mar Nursing Home
417 Pearl St., Columbus
Mildred H. Dooley, Adm.

Shady Nook Rest Home
R. R. 8, Columbus
Louanna Niemoeller, Adm.

Shanklin Nursing Home
705 Sycamore St., Columbus
Louisa Branum, Adm.

BENTON COUNTY

Mary's Nursing Home
Maple & Elm, Earl Park
Mary Belange, Adm.

BLACKFORD COUNTY

Jackson Nursing Home #1
423 S. Main St., Montpelier
Rolland W. Jackson, Adm.

Jackson Nursing Home #2
110 E. Huntington St., Montpelier
Rolland W. Jackson, Adm.

Waldo House
511 W. Washington St., Hartford City
Martha Waldo, Adm.

BOONE COUNTY

English Nursing Home
1015 N. Lebanon, Lebanon
Bessie May English, Adm.

Fultz Nursing Home
40 S. Third St., Zionsville
Jack E. Fultz, Adm.

Harris Nursing Home
210 S. Pearl St., Thorntown
Maud Harris, Adm.

Indiana Baptist Home, Inc.
R. R. 1, Zionsville
Loren E. Moore, Adm.

Maple Lawn Nursing Home
195 N. Maple, Zionsville
Helena B. Davis, Adm.

CARROLL COUNTY

Cornell Nursing Home
Cutler
Viola V. Cornell, Adm.

Deer Creek Nursing Home
R. R. 1, Camden
Mabel E. Bechdolt, Adm.

Fix Community Home, Inc.
404 S. Center St., Flora
Charles E. Fix, Adm.

Fix Community Home, Inc., of Delphi
321 E. Monroe, Delphi
Charles E. Fix, Adm.

Good Will Nursing Home
Main and Monroe Sts., Camden
Thomas and Mildred Shockley, Adms.

CASS COUNTY

Rest Haven Home
731 North St., Logansport
Olive S. Jones, L.P.N., Adm.

Webster Nursing Home
806 North St., Logansport
Nora B. Webster, Adm.

CLARK COUNTY

Hillcrest Nursing Home, Inc.
203 Sparks Ave., Jeffersonville
A. Lyle Havens, M.D., Adm.

The Ladies Home, Inc.
330 W. Market St., Jeffersonville
Anna Schimpff, Adm.

Maple Court Nursing Home
109 E. Maple Court, Clarksville
Goldie G. and Lola C. Hollingsworth, Adms.

Perkins Nursing Home
1315 Spring St., Jeffersonville
Dovie Perkins, Adm.

Twilight Nursing Home #1
210 E. Maple St., Jeffersonville
Delilah Jean Goodwin, Adm.

Twilight Nursing Home #3
418 Riverside Dr., Jeffersonville
Delilah Jean Goodwin, Adm.

CLAY COUNTY

MaCanell Nursing Home
R. R. 2, Box 139, Center Point
Hugh W. McCann, Adm.

Porter's Rest Home
R. R. 5, Brazil
Clint A. and Audrie Porter, Adms.

Wilson Nursing Home
525 E. Mechanic St., Brazil
Mary I. Wilson, Adm.

CLINTON COUNTY

Ashley Nursing & Convalescent Home
R. R. 6, Frankfort
Francis J. and Jean A. Hladik, Adms.

Bisel Nursing Home
551 E. Walnut St., Frankfort
B. H. Bisel, Adm.

Brock Nursing Home
R. R. 4, Frankfort
Everett and Margaret Brock, Adms.

Brown's Christian Nursing Home
R. R. 1, Michigantown
Irene Brown, Adm.

Mulberry Lutheran Home, Inc.
State Route 38, W. Jackson St., Mulberry
Rev. Russell Bussabarger, Adm.

Newton Convalescent Home
1201 E. Washington St., Frankfort
Westine Newton, R.N., Adm.

Rice Nursing Home
R. R. 1, Michigantown
Marie Rice, Adm.

Shoemaker Memorial Home
951 E. Clinton St., Frankfort
Rev. R. E. Nibarger, Adm.

Summers Convalescent Home
552 S. Columbia St., Frankfort
Florence B. Summers, Adm.

DAVIESS COUNTY

Colvin Nursing Home
1109 National Highway, Washington
Laura Colvin, Adm.

Godwin Nursing Home
819 Axtell Ave., Washington
Lelah Godwin, Adm.

Meyers Nursing Home
215 W. Oak St., Washington
Rosetta Meyers, Adm.

DEARBORN COUNTY

Shady Nook Convalescent Home
Ridge Ave., and Catalpa St., Lawrenceburg
Alta McMullen, Adm.

DECATUR COUNTY

Ada Schwind Nursing Home
469 S. Monfort St., Greensburg
Ada Schwind, Adm.

Jessup Nursing Home
Westport
Margaret F. VanBriggle, Adm.

Jessup Nursing Home #2
303 Jackson St., Greensburg
Margaret F. VanBriggle, Adm.

Odd Fellows Home
R. R. 8, Greensburg
William F. Hamilton, Adm.

Paul-Ann Nursing Home
320 S. Michigan Ave., Greensburg
Paul E. and Ann Johnson, L.P.N., Adms.

Ridout Nursing Home
410 S. Broadway, Greensburg
Doris Wilson and Ruth Harrelson, Adms.

Slone's Nursing Home
515 W. Main St., Greensburg
Marie Slone, Adm.

DEKALB COUNTY

Barkley Nursing Home
610 S. Broadway, Butler
Audrey E. Barkley, Adm.

Betz Nursing Home
R. R. 3, Auburn
Everett and Doris Betz, Adms.

Butler Hotel Rest Home, Inc.
117 S. Broadway St., Butler
Dorothy Dickerhoof, Adm.

Garrett Convalescent Home
611 S. Peters St., Garrett
Carlson and Mary Platz, Adms.

Sheehy Nursing Homes, Inc.
402 N. Broadway St., Butler
Flo Sheehy, Adm.

Southview Nursing Home
131 W. Depot St., Butler
Marjorie Harrold, Adm.

DELAWARE COUNTY

Bethel Nursing Home
R. R. 7, Muncie
Emogene E. Turner, Adm.

Chrystal's Country Home
R. R. 1, Selma
Crystal V. Steele, L.P.N., Adm.

Eads Nursing Home
R. R. 7, Muncie
Epsy W. Eads, Adm.

Faulkner Rest Home
905 S. Grant St., Muncie
Edgar Faulkner, Adm.

Frazee Convalescent Home
R. R. 2, Dunkirk
Bliss Frazee, Adm.

Golden Rule Nursing Home
410 N. Madison St., Gaston
Eunice A. Messersmith, L.P.N., Adm.

Maple Grove Convalescent Home
1347 East Jackson St., Muncie
Pearl B. Harty, Adm.

Morgan-Nickols Convalescent Home
727 Wheeling Ave., Muncie
Margaret L. Nickols, Adm.

Morgan-Nickols Residential Club
175 Kilgore, Muncie
Margaret L. Nickols, Adm.

Riverview Convalescent Home
R. R. 2, Burlington Dr., Muncie
Nila M. Harty, Adm.

Shady Haven Rest Home
R. R. 6, Bethel Pike, Muncie
Leila C. Wilcox, Adm.

Sylvester Home for the Aged
R. R. 5, Burlington Dr., Muncie
Nellie V. Sylvester, R.N., Adm.

Woodland Home #1
917 E. Main St., Muncie
Hazel Wilson, R.N., Adm.

Woodland Home #2
1612 W. Jackson, Muncie
Hazel Wilson, R.N., Adm.

DUBOIS COUNTY

Indiana Rest Home
115 E. Fifth St., Jasper
Matilda Sauter, Adm.

Jasper Nursing Home
102 W. Seventh St., Jasper
Lola M. Wehrle, Adm.

Providence Home
W. Ninth Street, Jasper
Rev. Phillip Ottavi, Adm.

St. Ann Nursing Home
511 Fourth St., Huntingburg
Sister M. Josepha, R.N., Adm.

ELKHART COUNTY

The Austin Home
526 N. Sixth St., Goshen
Hazel M. Neibert, Adm.

Gay Peterson Nursing Home
302 E. Lincoln Ave., Goshen
Iva Gay Peterson, Adm.

Hutchinson Nursing Home
302 S. Sixth St., Goshen
Irene Hutchinson, Adm.

Ideal Rest Home
925 Monroe St., Elkhart
Bonnie Sills, Adm.

Lu-Ann Nursing Home
952 W. Walnut St., Nappanee
Lucille Sechrist, R.N., Adm.

Milleman Convalescent Home, Inc.
430 W. Marion St., Elkhart
Herold A. and Hazel Milleman, Adms.

Nicholson Convalescent Home
2400 Elkhart Rd., Goshen
George and Gracia Nicholson, R.N., Adms.

Rest Haven Nursing Home
803 Wolf Ave., Elkhart
Elizabeth Calabrese, Adm.

Riley Convalescent Home
527 S. Main St., Goshen
Albert and Eunice Riley, L.P.N., Adms.

Simpson Nursing Home
114 S. Sixth St., Goshen
Richard A. Simpson, Adm.

Thorp Nursing Home
621 E. Vistula St., Bristol
Ruth G. Thorp, Adm.

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Welcome Home
1429 Krau, Elkhart
Josephine Ellsworth and Dorothy Metz, Adms.

Westview Convalescent Home
2600 S. Morehouse Ave., Elkhart
David Bair, Adm.

Wilson Nursing Home
901 S. Second St., Elkhart
Neva B. Wilson, L.P.N., Adm.

Wiltrev Rest Home
1005 S. Third St., Elkhart
Neva B. Wilson, L.P.N., and Treva M. Criss, Adms.

FAYETTE COUNTY

Lincoln Manor Nursing Home
903 Lincoln Ave., Connersville
Chester C. O'Neal, Adm.

Paula-Mar Nursing Home
319-21 Western Ave., Connersville
Paul E. and Mary M. Harvey, Adms.

FLOYD COUNTY

Happy Haven Rest Home
911 E. Spring St., New Albany
Donald Napper, Adm.

Kingston Nursing Home
1317 Culbertson, New Albany
Bessie Kingston, Adm.

Providence Retirement Home
703 E. Spring St., New Albany
Sister Catherine Loretta, Agent

Turley's Nursing Home
1003 E. Main St., New Albany
Anna C. Turley, Adm.

FOUNTAIN COUNTY

Alward Nursing Home
605 Summit St., Attica
Leston and Imogene B. Alward, R.N., Adms.

Rudisill Nursing & Convalescent Home
303 Second St., Covington
Owen G. Rudisill, Adm.

FRANKLIN COUNTY

Echo Hill Nursing Home
R. R. 2, Laurel
Myrtle Jackson, Adm.

Elsie Dreyer Nursing Home #3
273 Main St., Brookville
Elsie Dreyer, Adm.

FULTON COUNTY

Miller Nursing Home
719 Madison St., Rochester
Helen Miller, Adm.

Pontius Nursing Home
426 Jefferson St., Rochester
Mrs. Raymond (Pearl) Pontius, Adm.

Rochester Nursing Home
1118 Main St., Rochester
Gerald L. Eastburg, Adm.

GIBSON COUNTY

Church Nursing Home
417 W. Broadway, Princeton
Edra E. Waldron, Adm.

Colonial Nursing Home
314 N. West St., Princeton
Bessie G. Mitchell, Adm.

Good Samaritan Home
210 N. Gibson Rd., Oakland City
Buthyl and Roxie G. Hedges, Adms.

Hottel Nursing Home
East Main St., Francisco
Lillian A. Hottel, Adm.

Maxey Nursing Home
Main St., Box 53, Haubstadt
Pearless and Marie Maxey, Adms.

Oakland City Rest Home
114 Grove St., Oakland City
Otto Blubaum, Adm.

Shady Grove Nursing Home
Francisco
Ruth Morris, Adm.

GRANT COUNTY

Calbert Nursing Home, Inc.
221 N. Washington St., Marion
Shirley Dean Brown, L.P.N., Adm.

Calbert's Rest Home
204 N. Washington St., Marion
Wanda Whitaker, Adm.

Ellen Hill Home, Inc.
710 W. Third St., Marion
Opal E. Calbert, Adm.

Friendship Heights Rest Home
704 S. Main St., Fairmount
Jess and Margaret Lyons, Adms.

Jones Convalescent Home, Inc.
518 W. 36th St., Marion
Carroll M. Jones, Adm.

Jones Nursing Home
P. O. Box 102, Fowlerton
Carroll Jones and Betty Jones, L.P.N., Adms.

GREENE COUNTY

Glenburn Rest Haven
Glenburn Rd., R. R. 2, Linton
Nola D. Yoder, Adm.

HAMILTON COUNTY

Arcadia Rest Home
405 S. East St., Arcadia
Florence Sigler, Adm.

Hamilton Rest Home
15755 Allisonville Rd., Noblesville
Mary E. McKinley, Adm.

Lakeview Guest Home
R.R. 1, Box 15, Carmel
Seth Wells, Adm.

Sunderman Nursing Home
69 N. Harrison St., Cicero
Bernard and Belva Sunderman, Adms.

HANCOCK COUNTY

Pleasant Acres
R. R. 12, Box 320, Indianapolis
Frederick M. and Lorna Burns, L.P.N., Adms.

Twinbrook, Inc.
R. R. 4, Box 66, Greenfield
James L. Kavalaris, Adm.

Wood Nursing Home
14 N. Wood St., Greenfield
Hazel E. Wood, L.P.N., Adm.

HARRISON COUNTY

The Capitol Rest Home
408 N. Capitol Ave., Corydon
Mary E. Dailey, Adm.

HENDRICKS COUNTY

Danville Nursing Home
64 N. High St., Danville
Pearl Perkins, Adm.

Golden Rule Nursing Home
147 S. Wayne St., Danville
Robert and Ethel Petree, Adms.

Vinewood Nursing Home
404 North Vine St., Plainfield
Stephen Snyder, Adm.

HENRY COUNTY

"The Boxwoods" Nursing Home
115 N. 10th St., New Castle
Margaret Harris, L.P.N., Adm.

Hammond Nursing Home
806 W. Broad St., New Castle
Betty I. Hammond, L.P.N., Adm.

Middletown Nursing Home
130 S. 10th St., Middletown
Robert I. Clevenger, Adm.

New Hope Nursing Home
Lewisville
Mildred King, Adm.

Rest Haven
420 S. Main St., New Castle
Dorothy Shipp, R.N., Adm.

HOWARD COUNTY

Hillcrest Nursing Home
1210 E. Jefferson St., Kokomo
Sarah Naomi Miller, Adm.

Kokomo Convalescent Center
429 Lincoln Rd. W., Kokomo
Donald L. Meyer, Adm.

Lucy Cole Nursing Home
332 W. Markland, Kokomo
Lucy Cole, L.P.N., Adm.

Pleasant Rest
508 W. Taylor St., Kokomo
Homer E. and Frances T. Johnson, Adms.

Samaritan Home of Kokomo, Inc.
513 East Vaile Ave., Kokomo
Sister Raphael, Adm.

HUNTINGTON COUNTY

Hillcrest Nursing Home
959 Guilford, Huntington
Jeanette Crumley, Adm.

Our Golden Years Home
442 Grayston Ave., Huntington
Mrs. Charles J. Smith, Adm.

Roanoke Nursing Home, Inc.
743 N. Main Street, Roanoke
Robert and Joyce Barna, Adms.

Town & Country Nursing Home
Goshen Rd., Huntington
Hal B. and Ann Lunsford, Adms.

JACKSON COUNTY

Rose Lawn Home Annex
305 St. Louis Ave., Seymour
Esta T. Martin, Adm.

Rose Lawn Nursing Home
202 W. Sixth St., Seymour
Lowell E. and Marcia Martin, Adms.

West Side Nursing Home
108 S. Pine St., Seymour
Jennie West and Harriette Rebholz, Adms.

JASPER COUNTY

Remington Rest Home
Illinois and Minnesota Sts., Remington
E. Max Sullivan, Adm.

JAY COUNTY

Portland Nursing Home, Inc.
406 W. Arch St., Portland
Mary Ellen Hearn, Adm.

JEFFERSON COUNTY

Hilltop Rest Home
352 Miller, Madison
Louise Obertate, Adm.

Madison Nursing Home
726 W. Main St., Madison
Ella Shuell, R.N., Adm.

JOHNSON COUNTY

Faith Home
P. O. Box 65, Edinburg
Raymond C. Brown, Adm.

Greenwood Hilltop Nursing Home
R. R. 2, Fry Rd., Greenwood
Violet Van Sickle, Adm.

Hardin's Nursing Home
400 Kentucky St., Franklin
James S. and Bertha L. Hardin, Adms.

Indiana Masonic Home
Franklin
Roy O. Turner, Adm.

Indiana Retired Teacher's Community
Greenwood Village, Greenwood
Sumner L. Martin, Adm.

Janie's Nursing Home
651 S. State St., Franklin
Janie Johnson, L.P.N., Adm.

Methodist Home for the Aged
Franklin
A. M. Brown, D.D., Adm.

The Welcome Nursing Home
1109 N. Main St., Franklin
Stephen J. Snyder, Adm.

KNOX COUNTY

Freelandville Community Home, Inc.
Freelandville
Lorena Walters, R.N., Adm.

Ideal Nursing Home
402 Broadway, Vincennes
Cora Thornberry Joyce, Adm.

Moore's Nursing Home
204 W. Third St., Bicknell
Ernest P. and Barbara J. Moore, Adms.

Restwell Home, Inc.
1321 Willow St., Vincennes
Warren J. Mauck, Adm.

Turner Nursing Home
515 Perry St., Vincennes
Clyde W. and Marylee Turner, R.N., Adms.

Vincennes Nursing Home
703 Prairie St., Vincennes
Fern Junod, Adm.

KOSCIUSKO COUNTY

Alfrau Nursing Home
2501 E. Center St., Warsaw
Frank N. and Alice Wilson, R.N., Adms.

Hillcrest Manor
519 W. Winona Ave., Warsaw
John E. Mast, Adm.

Kilgore Nursing Home
R. R. 1, Pierceton
Violet Kilgore, Adm.

Orn Nursing Home
North Main St., Milford
Mrs. Amos Orn, Adm.

Pierceton Nursing Home
Indiana and Main Sts., Pierceton
Frank and Alice Wilson, R.N., Adms.

Prairie View Rest Home, Inc.
300 Prairie St., Warsaw
Hazel Bradbury, L.P.N., Adm.

LAGRANGE COUNTY

Marks' Nursing Home
R. R. 1, LaGrange
Marie B. Marks, Adm.

LAKE COUNTY

Blair Nursing & Convalescing Home
7606 Rhode Island Ave., Hammond
Mary Ann Blair, L.P.N., Adm.

Calloway Nursing Home
1948 Massachusetts St., Gary
Tomye D. Calloway, Adm.

Calloway Nursing Home
1558 Fillmore St., Gary
Tomye D. Calloway, Adm.

Gary Convalescent Home, Inc.
386 Mount St., Gary
Joseph Shapiro, M.D., Adm.

Gearlds Rest Home
726 Sibley St., Hammond
Vida B. Gearlds and Mary H. Bailey, Adms.

Great Oaks Manor Convalescent Home
R. R. 1, Box 30, Cedar Lake
William J. and Virginia Moodie, R.N., Adms.

Green's Home
3960 Massachusetts St., Gary
Lillian Green, Adm.

Hilltop Nursing Home
R. R. 2, Box 279, Crown Point
David and Olive Beggs, Adms.

Jayne Bryant Nursing Home
P. O. Box 166, Crown Point
Ellen Jayne Bryant, Adm.

Laura S. Beaton Nursing Home Inc.
521 Pennsylvania St., Gary
Laura S. Beaton, Adm.

Maplecrest Nursing Home
P. O. Box 114, St. John
George and Cecelia Klisurich, Adms.

Miller Nursing Home
2301 Adams St., Gary
Ida Miller, Adm.

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Mills Rest Home
5011 Maryland St., Gary
Audrey Mills, Adm.

St. Ann's Home
5927 Columbia Ave., Hammond
Sister Mary Laura, Adm.

St. Anthony's Convalescent Home
R. R. 1, Box 262, Crown Point
Sister Mary Ottilia, Adm.

S & S Nursing Home
1944 Maryland St., Gary
LaGora Sanders and Anna L. Simmons, Adms.

Shady Heights Nursing Home
R. R. 1, Box 46, Dyer
Faye McGuire, L.P.N., Adm.

West End Nursing Home
1501 Wheeler St., Gary
Henderson D. Hall, Adm.

West Side Nursing Home
829 W. Third Ave., Gary
Stuart Primack, Adm.

Willowdale Convalescent Home
R. R. 2, Box 410, Crown Point
Donald D. DuSold, M.D., Adm.

Woodmar Nursing Home
6727 Baring Ave., Hammond
Geraldine Wiseley, Adm.

LAPORTE COUNTY

Anderson Sanitarium
504 I St., LaPorte
Carroll and Lula Anderson, Adms.

Beach Cliff Lodge Nursing Home
1001 Lake Shore Dr., Michigan City
Theodore Moss, Adm.

Hampton Nursing Home
Michigan and Wolfe Ave., Michigan City
Charlie and Mary Hampton, Adms.

Schofield Home
602 Spring Street, Michigan City
Florence D. Schofield, Adm.

Stites School Nursing Home
State Rd. 39 and County Rd. 900 N., LaPorte
Roger J. Schofield, Adm.

Waterford Nursing Home
R. R. 3, Box 319, Michigan City
Mary Ellen Poffenberger, Adm.

White Tower Nursing Home
209 State Street, LaPorte
Jane E. Gittings, Adm.

LAWRENCE COUNTY

Gladys' Nursing Home
51 East 16th St., Bedford
Gladys Keller, Adm.

Oolitic Rest Home
North Lafayette St., Oolitic
Edna Perry, Adm.

Parkview Nursing Home
2111 Norton Lane, Bedford
Irma C. Hendricks, Adm.

Rest Haven Nursing Home
1010 W. Frank St., Mitchell
Kathleen King and Dorothy Sheeks, Adms.

Sunny Acres Rest Home
R. R. 5, Bedford
Mabel Ray, Adm.

MADISON COUNTY

Bradford Nursing Home
625 W. Adams St., Alexandria
Alma Bradford, Adm.

Bright Memorial Nursing Home
2006 Jackson St., Anderson
Evelyn E. Teter, Adm.

Dickey Nursing Home
220 N. Ninth Street, Elwood
Louise Dickey, Adm.

Farrington Nursing Home
818 W. Washington St., Alexandria
Alma C. Farrington, Adm.

Goble Home
332 W. 11th St., Anderson
Martha Keller, Adm.

Miramar Nursing Home
1901 N. "A" St., Elwood
James G. Dickey, Adm.

New Haven Nursing Home
1023 E. Eighth St., Anderson
Josephine Wade, L.P.N., Adm.

Northside Nursing Home
900 North J. St., Elwood
Louise Dickey, L.P.N., Adm.

Rahbek Nursing Home
711 W. 5th St., Anderson
Jack V. and Rosemary L. Williamson, R.N., Adms.

Scott Nursing Home
339 S. Broadway, Pendleton
Ruby Scott, Adm.

Shipley's Nursing Home
2417 Pearl St., Anderson
Mildred Shipley, Adm.

Westside Nursing Home
416 W. 12th St., Anderson
Marian Webb, L.P.N., Adm.

MARION COUNTY

Ada's Golden Age Sanitorium
2115 Central Ave., Indianapolis
John Gerhart, Pres.

Alpha Home for Aged
1840 Senate Ave., Indianapolis
Maude Gaillard, Adm.

Anthony Hall Nursing Home
2135 N. Alabama St., Indianapolis
Rev. James W. Jones, Adm.

The Barton House
505 N. Delaware, Indianapolis
Stephen J. Snyder, Adm.

Bel-Terrace Nursing Home
1629-33 N. College Ave., Indianapolis
Stephen J. Snyder, Adm.

Booker-Watts Convalescent Home
1409 Bellefontaine St., Indianapolis
Geneva B. Watts, Adm.

Booker-Watts Convalescent Home
812 E. 14th St., Indianapolis
Geneva B. Watts, Adm.

Borinstein Home for Jewish Aged, Inc.
3516 Central Ave., Indianapolis
Vida Oakley, Adm.

Broad Brook Restorium
1445 Broadway, Indianapolis
Nora Brooks. L.P.N., Adm.

Central Nursing Home
2262 Central Ave., Indianapolis
Bertha Flagle, Adm.

Colonial Crest, Inc.
7149 E. 21st St., Indianapolis
Twyla L. Cross, Pres.

Conner Nursing Home
1408 N. Pennsylvania St., Indianapolis
Lucy V. Conner, Adm.

Dumas Nursing Home
2712 N. Illinois, Indianapolis
Mary Lou Dumas, R.N., Adm.

Evangelistic Center, Inc.,
3518 Shelby, Indianapolis
Rev. E. P. Qualls, Adm.

Frame Nursing Home
373 N. Holmes Ave., Indianapolis
Bert and Marybell Frame, Adms.

Garfield Park Nursing Home
2605 Shelby Street, Indianapolis
Thelma Bryant, L.P.N., Adm.

Garner's Nursing Home
1402 Carrollton Ave., Indianapolis
Elizabeth Garner, Adm.

Harris Sanatorium, Inc.
4601 N. Keystone, Indianapolis
John G. Harris, Adm.

Hillside Nursing Home
2370 Hillside Ave., Indianapolis
Bennie Mason, Adm.

Huff's Sanitarium
115 S. Audubon Rd., Indianapolis
Bettina Sullivan, Adm.

Limpus Nursing Home
236 S. Ritter Ave., Indianapolis
Frances Limpus, Adm.

The Lou-Wise
2516 Central Ave., Indianapolis
Bessie Cook, L.P.N., Adm.

Lynhurst Nursing Home
5225 W. Morris St., Indianapolis
James H. Hills, Sr., and Ethel L. M. Herron, Adms.

Marie Fred Nursing Home
604 N. Jefferson Ave., Indianapolis
Marie Fred, R.N., Adm.

Martin's Convalescent Home
1621 Park Ave., Indianapolis
Lucille Martin, Adm.

Memorial Nursing Home, Inc.
41 W. 32nd St., Indianapolis
Richard L. Albright, Sec-Treas.

Midland House, Inc.
3302 Washington Blvd., Indianapolis
Thomas C. Keller, Adm.

New View Nursing Home
1429 Carrollton Ave., Indianapolis
Maude E. Weaver, Adm.

Northwestern Convalescent Home
2413 Northwestern Ave., Indianapolis
James H. McKenzie, Adm.

Penn Rest Home
2014 N. Pennsylvania, Indianapolis
John Gerhart, Pres.

People's Nursing Home
2354-56 N. College Ave., Indianapolis
Rev. James and Marceline Jones, R.N., Adms.

Petty Nursing Home
2432 Central Ave., Indianapolis
Gailord S. and Elsie Petty, Adms.

Pike Sanitarium
2037 N. Illinois St., Indianapolis
John Gerhart, Pres.

Pleasant View Rest Home
5000 Southeastern Ave., Indianapolis
Laura E. Weber, Adm.

Robinson's Private Home
2254 Central Ave., Indianapolis
Eunice Robinson, Adm.

St. Paul Baptist Church Home for the Aged
1141-45 N. Sheffield Ave., Indianapolis
Rev. C. J. Dailey, Adm.

St. Paul Hermitage
501 N. 17th St., Beech Grove
Sister M. Bernice Kavanaugh, O.S.B., Adm.

Sarah's Nursing Home
2716 Sutherland Ave., Indianapolis
Sarah Hill, Adm.

Springer's Nursing Home
6566 W. Washington St., Indianapolis
Millard and Gladys Springer, Adms.

Tall Cedars Home
8327 W. Washington St., Indianapolis
Ora A. Torrence, Adm.

T. Wray Nursing Home
1812 Central, Indianapolis
Thelma F. Wray, L.P.N., Adm.

Three Sisters Nursing Home
125 W. 26th St., Indianapolis
Esther, Etta and Horty Springfield, Adms.

Vollmer Convalescent Home
2630 College Ave., Indianapolis
Emory H. Vollmer, Adm.

Mabel S. Waddle Private Home
2112 N. Delaware St., Indianapolis
Mabel S. Waddle, Adm.

Ward Nursing Home
1518 N. Senate Ave., Indianapolis
Willa Mae Murray, Adm.

Weber Convalescent Home
43 S. Ritter Ave., Indianapolis
Laura E. Weber, Adm.

Wert Nursing Home
1716-18 N. New Jersey, Indianapolis
Edith M. Wert, Adm.

Wooldridge Nursing Home
624 E. 12th St., Indianapolis
Albert H. and Patricia A. Wooldridge, Adms.

MARSHALL COUNTY

Fairview Nursing Home
Route 4, Plymouth
Mabel Beam, Adm.

I.B.M. Nursing Home
1029 W. Jefferson St., Plymouth
Iva B. Miller, Adm.

Klapp Nursing Home
145 S. Michigan, Argos
Doris I. Klapp, Adm.

Landis Nursing Home
115 S. Maple Ave., Argos
Nerla L. Dykes, Adm.

Myers Nursing Home
R. R. 3, Box 159, Bremen
Pearl Myers, L.P.N., Adm.

MARTIN COUNTY

O'Maley Rest Home
R. R. 4, Loogootee
Fred W. O'Maley, Adm.

MIAMI COUNTY

Armstrong's Park View Rest Home
402 Armstrong Ave., Peru
Zella C. Armstrong, L.P.N., Adm.

Church of the Brethren Home, Inc.
Mexico
Orville Sherman, Adm.

The Miami Home
77 E. Third St., Peru
H. Lucille McDaniel, Adm.

Peru Nursing Home
906 W. Main St., Peru
Margaret Harris, L.P.N., Adm.

MONROE COUNTY

Lemble Nursing Home
R. R. 7, Box 297, Bloomington
Judith Lemble, Adm.

Percifield Nursing Home
1031 W. Sixth St., Bloomington
Lucille Bales, Adm.

MONTGOMERY COUNTY

Ben Hur Home
1375 S. Grant, Crawfordsville
Martha E. Williams, Adm.

Hazel Small Rest Home
N. Vine St., Waynetown
Lee and Sarah Small, Adms.

Laura M. Bowles Convalescent Home, Inc.
1304 S. Grant Ave., Crawfordsville
Richard Bowles, L.P.N., Adm.

Westbrook Nursing Home
R. R. 9, Box 39, Crawfordsville
Mary E. Brooks, Adm.

MORGAN COUNTY

Cherry Nursing Home
60 E. Harrison St., Martinsville
Zepha Cherry, Adm.

Continued

NURSING HOMES

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Sullivan Nursing Home
Box 162, Morgantown
Marjorie Sullivan, Adm.

NOBLE COUNTY

C. J. Hocker Memorial Nursing Home
Wolflake
Thomas Wheeler and Lou Ann Foster, Adms.

Golden Rule Nursing Home
R. R. 1, Pierceton
H. F. and Eva Mock, Adms.

Jaquay's Nursing Home
324 Silver St., Kendallville
Leone Jaquay, Adm.

Kondas Nursing Home
R. R. 1, Albion
Steve and Julia Kondas, Adms.

Lutheran Old People's Home, Inc.
612 E. Mitchell, Kendallville
Rev. Herbert L. Wiese, Adm.

Sacred Heart Home
R. R. 2, Avilla
Sister Anna Marie, Adm.

Saint Vincent Home for the Aging
R. R. 1, Ligonier
Sister M. Agatha, R.N., Adm.

ORANGE COUNTY

Gorge Nursing Home, Inc.
R. R. 2, French Lick
Gertrude Haynes, R.N., and Myrtle Sumpson, R.N., Adms.

OWEN COUNTY

Donna Nursing Home #2
R. R. 2, Spencer
Clyde and Ursula Poff, L.P.N., Adms.

Gosport Nursing Home
W. Main St., Gosport
Mary F. Wampler, Adm.

Reapp Nursing Home
P. O. Box 87, Spencer
Jennie C. Reapp, Adm.

PARKE COUNTY

Allen Nursing Home
303 Howard Ave., Rockville
James F. Allen, Adm.

Ball Nursing Home
517 Ohio St., Rockville
Margaret Ball, Adm.

Bishop's Nursing Home
South Main St., Box 58
Bloomingdale
Darrell H. Bishop, Adm.

Britton's Parke County Nursing Home
R. R. 2, Rockville
Helen Britton, Adm.

Layman Nursing Home
603 S. Washington, Montezuma
Mildred Layman, Adm.

Wabash Valley Nursing Home
934 N. Jefferson St., Montezuma
James F. Allen, Adm.

PIKE COUNTY

Fay's Convalescent Home
210 S. 14th St., Petersburg
Fay France, Adm.

Petersburg Rest Home
1002 Main St., Petersburg
Donna M. Cooper, Adm.

PORTER COUNTY

Beverly Shores Nursing Home, Inc.
Beverly Shores
John W. Bragg, Adm.

Valparaiso Nursing Home
359 Greenwich St., Valparaiso
Marie Goble, Adm.

POSEY COUNTY

Allison Nursing Home
Locust St., Poseyville
Lula Allison, Adm.

Burton's Nursing Home
North St., Cynthiana
Mary M. Burton, Adm.

Mt. Vernon Nursing Home
831 Mulberry St., Mount Vernon
Rena Green, Adm.

The Valley Rest Home
R. R. 4, Mount Vernon
Raymond E. and Esther M. Faulkner, Adms.

PUTNAM COUNTY

Craver Nursing Home
"E" Street, Greencastle
Hannah Craver, Adm.

Donna Nursing Home #1
Main St., Cloverdale
Ursula Poff, L.P.N., Adm.

Eventide Rest Home
R. R. 2, Greencastle
Cletus O. and Daisy L. Sult, R.N., Adms.

Ruark Nursing Home
R. R. 1, Fillmore
Elsie C. Ruark, Adm.

RANDOLPH COUNTY

Golden Rule Rest Home
300 S. Meridian St., Winchester
Bernice E. Puterbaugh, R.N., Adm.

Lamb's Nursing Home
R. R. 4, Union City
Bernice A. Lamb, Adm.

Parrott's Home
304 W. Sherman St., Lynn
Willie R. and Mary Maxine Parrott, Adms.

RIPLEY COUNTY

Elsie Dreyer Nursing Home #1
Main St., Sunman
Elsie Dreyer, Adm.

Elsie Dreyer Nursing Home #2
R. R. 1, Sunman
Elsie Dreyer, Adm.

Gilland Nursing Home #1
310 Cravens St., Osgood
Dan and Mildred Gilland, Adms.

Gilland Nursing Home #2
120 E. Ripley St., Osgood
Mildred Gilland, Adm.

Gilland Nursing Home #3
Glasgow and Willson, Osgood
Dan and Mildred Gilland, Adms.

Health and Hospitality Center
Carr St., Milan
Alfred J. Colson, Adm.

Twilight Haven Convalescent Home
High Street, Versailles
Freeda Hensley, Adm.

RUSH COUNTY

Hillside Haven
424 North Perkins St., Rushville
Mary Todd, R.N., Adm.

Jackson Nursing Home
114 E. Fifth St., Rushville
Goldie Jackson, L.P.N., and Marjorie Pearsey, L.P.N., Adms.

Rushville Nursing Home
321 N. Morgan St., Rushville
Marjorie Fordyce, Adm.

Rowland's Nursing Home
230 E. Seventh St., Rushville
Willard and Nora Lee Rowland, Adms.

ST. JOSEPH COUNTY

Barbara Morrow Home
1107 S. Main St., South Bend
Barbara Morrow, Adm.

Calvert Convalescent Home
1844 E. Calvert, South Bend
Mildred Feldbauer, R.N., Adm.

Cardinal Convalescent Center, Inc.
118 S. Williams St., South Bend
Dorothy Berger, R.N., Adm.

Dor-A-Lin, Inc.
1024 N. Notre Dame Ave., South Bend
Edward L. Finkenbinder, Adm.

Farris Nursing Home
1021 W. Washington St.,
South Bend
Helen M. Farris, Adm.

Farris Nursing Home #2
1044 Lincolnway West,
South Bend
Helen M. Farris, Adm.

Gugle Nursing Home
714 West Oak St., South Bend
Myrtle B. Joyce, Adm.

Hall Nursing Home
702 S. Columbia St., South Bend
William G. Swintz and Thomas Squibb, Adms.

Haven Hubbard Memorial Home
New Carlisle
Mearl L. Dustin, Adm.

Hillview Convalescent Home
601 Russell St., Mishawaka
Rosabelle Buck, R.N., Adm.

The Jeffrey, Inc.
909 27th St., South Bend
James J. Pallatin, Adm.

Krogh Nursing Home
109 N. Cedar St., Mishawaka
Joyce Wood, L.P.N., Adm.

Lambie Nursing Home
832 W. Colfax St., South Bend
Audrey J. Lambie, Adm.

Nemeth Nursing Home
1145 W. Napier St., South Bend
Peggy and Michael Nemeth, Adms.

River Park Nursing Home
2706 Wall St., South Bend
William G. Swintz and Thomas E. Squibb, Adms.

Rockhill Nursing Home
1526 Lincoln Way West,
South Bend
Lillie A. Rockhill, L.P.N., Adm.

Sunnybrook Nursing Home
605 Portage Ave., South Bend
Pauline Luther, Adm.

Terry King Nursing Home
816 W. Colfax, South Bend
Calvin Laisure, Adm.

Terry King Nursing Home #3
1209 S. Union, Mishawaka
Gloria McCullough, Adm.

Walkerton Nursing Home
500 Roosevelt Road, Walkerton
Virginia Waldron, L.P.N., Adm.

Wilton Rest Home
25419 St. Rt. 2, South Bend
William Grzywinski, Adm.

SCOTT COUNTY

Shalom Nursing Home
910 Woodland Ave., Scottsburg
Marvin L. and Patricia Richey, Adms.

SHELBY COUNTY

Ace Placid Home
R. R. 1, Fairland
Dewey F. Murphy, Adm.

Conover Rest Home
R. R. 1, Box 248, Morristown
Charles and Barbara Conover, Adms.

Maples Convalescent Home
R. R. 1, Fountaintown
Max D. McGraw, Adm.

Shelbyville Rest Home
125 W. Washington, Shelbyville
Laura Oma Gosch, Adm.

Waldron Nursing Home
Main St., P. O. Box 127,
Waldron
Evelyn V. Nasby, R.N., Adm.

SPENCER COUNTY

Boyd Nursing Home
513 Walnut St., Rockport
Mamie Boyd, Adm.

Ophelia's Rest Home
807 Main St., Rockport
Ophelia Moore, Adm.

STARKE COUNTY

Healthmore Nursing Home
P. O. Box 103, Hamlet
Paul Q. and Berniece Zellers, R.N., Adms.

Little Company of Mary Hospital and Home for Chronically Ill., Inc.
Route 421, San Pierre
Mother M. Catherine, Adm.

Ruff Nursing Home
Culver Road, Knox
Mrs. Levert Ruff, Adm.

STEUBEN COUNTY

Adams Nursing Home
314 W. Broad St., Angola
Lois June Adams, Adm.

Angola Rest Home, Inc.
306 N. Wayne St., Angola
Ruth G. Libby, Adm.

Edith Nursing Home
116 Powers St., Angola
Edith Smith, Adm.

Underwood Nursing Home
Box 8, Defiance St., Pleasant Lake
Paul and Mary Underwood, Adms.

TIPPECANOE COUNTY

Battle Ground Nursing Home
Jewett St., Battle Ground
John D. Gerhart, Adm.

Burnett Nursing Home
221 S. Ninth St., Lafayette
Maude L. Golden, L.P.N., Adm.

Campbell Nursing Home
641 New York St., Lafayette
Alma Campbell, L.P.N., Adm.

Comfort, Inc.
312 N. Eighth St., Lafayette
Allen C. and Clara E. Campbell, R.N., Adms.

Indiana Knights of Pythias Home, Inc.
1501 South 18th Street,
Lafayette
Clarence Hole, Adm.

Laura M. Bowles Convalescent Home
147 Ford St., Clarks Hill
Laura M. Bowles, L.P.N., and Laura L. Peterson, Adms.

Lesley Nursing Home
Buck Creek
Rosina Lesley, Adm.

Pickett Nursing Home
1021 N. Seventh St., Lafayette
Verna I. Pickett, Adm.

Scott Nursing Home
1100 N. Ninth St., Lafayette
Goldie Scott, Adm.

TIPTON COUNTY

The Higgins Home
R. R. 1, St. Rd. 19, Tipton
Robert D. and Eileen G. Higgins, Adms.

UNION COUNTY

Lemmons Nursing Home
208 Line St., Liberty
Neva P. Lemmons, Adm.

Llewellyn Nursing Home
Mound and Center Sts., West., College Corner
Vera Llewellyn, Adm.

Park Manor Nursing Home, Inc.
409 E. Union St., Liberty
Helen Ann Ray, L.P.N., Adm.

VANDERBURGH COUNTY

Bethany Rest Home
316 N. Wabash Ave., Evansville
Edith M. Poole, Adm.

Bethel Sanitarium, Inc.
800 Mary Street, Evansville
Louise Kuiken, R.N., Adm.

Bethel Sanitarium, Inc.
6015 Kratzville Rd., Evansville
Louise Kuiken, R.N., Adm.

Continued

NURSING HOMES

Continued

Bethel Sanitarium, Inc., Annex
5827 Kratzville Rd., Evansville
Louise Kuiken, R.N., Adm.

Braun's Nursing Home
909 First Ave., Evansville
Roy L. and Ruth H. Braun, Adms.

Dorsey Nursing Home
1714 S. Governor St., Evansville
Laura Dorsey, Adm.

Evans Nursing Home
605 Oak St., Evansville
Anna Evans, Adm.

Gertha's Nursing Home
605 Oakley St., Evansville
Gertha Hendrickson, Adm.

Good Samaritan Home
601 N. Boeke, Evansville
Rev. Martin P. Kniker, Adm.

Kueber Nursing Home
816 First Avenue, Evansville
John and Catherine Kueber, Adms.

M & R Nursing Home
1100 N. Read St., Evansville
Mrs. Muriel Sprinkle, L.P.N., Adm.

Newton Rest Home
921-23 S. Elliott St., Evansville
Gwendolyn Newton, Adm.

Pine Haven
3401 Stocker Dr., Evansville
Anita M. Stocker, R.N., Adm.

Regina Pacis Home
3900 Washington Ave., Evansville
Rev. James R. Deneen, Adm.

Stinson Rest Home
315 S. E. Second St., Evansville
Mildred Stinson, Adm.

Thelma's Rest Home
807-11 S. E. Third St., Evansville
Thelma Shaw, Adm.

Tri-State Community Rest Home
821 Judson Street, Evansville
Soloman Stevenson, Acting Adm.

VERMILLION COUNTY

Dana Convalescent Home
Dana
Louise Barton, Adm.

Layman Nursing Home
432 S. Fifth St., Clinton
Mildred Layman, Adm.

VIGO COUNTY

Cook Nursing Home
2058 N. Seventh St., Terre Haute
Grace E. Cook, Adm.

Ideal Rest Home
1452 Chestnut St., Terre Haute
Clarence and Evelyn Wallace, Adms.

Mary Etta Nursing Home
1524 Third Ave., Terre Haute
Mamie Mason, Adm.

Sharps Nursing Home
1432 N. Center St., Terre Haute
Hazel M. Sharps, Adm.

Sullivan Nursing Home
705 S. Seventh St., Terre Haute
Grace F. Sullivan, Adm.

Trainer Nursing Home
1915 N. 11th St., Terre Haute
Geneva Trainer, Adm.

Wallace Nursing Home
502 N. Eighth St., Terre Haute
Evelyn Wallace, Adm.

Wallace Nursing Home
1334 Sycamore St., Terre Haute
Evelyn Wallace, Adm.

Wallace Sanitorium
2144 Eighth Ave., Terre Haute
Evelyn Wallace, Adm.

WABASH COUNTY

The Estelle Peabody Memorial Home
Seventh and Buffalo, North Manchester
William Visser, Adm.

Friendly Nursing Home, Inc.
1420 Quaker Ave., Wabash
Jean Leakey, Adm.

Gore's Nursing Home
1250 Pike St., Wabash
Chester M. Gore, Adm.

Parrett Nursing Home
213 E. Hill St., Wabash
Wilmer and Kathleen Parrett, L.P.N., Adms.

Pleasant View Nursing Home
R. R. 2, Wabash
Virgil L. and Lois M. Sweares, Adms.

Pleasant Valley Retirement and Convalescent Lodge
Kramer
Walter R. and Dorothy D. Ruark, R.N., Adms.

WARRICK COUNTY

Baker's Rest Haven
503 West Walnut, Boonville
Viola Baker, Adm.

Hollis Nursing Home
R. R. 5, Boonville
Harvey and Loraine Hollis, Adms.

Shady Rest Nursing Home
Outer State Street, Chandler
Gilbert and Pearl Bradfield, Adms.

WASHINGTON COUNTY

Williams Nursing Home
R. R. 3, Scottsburg
Kathleen Williams, L.P.N., Adm.

Williams Convalescent Center, Inc.
Homer and Anson Sts., Salem
Kathleen Williams, Adm.

WAYNE COUNTY

Friendship Home
306 S. 10th St., Richmond
Grace Flatley, Adm.

Gains Nursing Home
R. R. 2, Richmond
Emma Gains, Adm.

Glen Aire Nursing Home
2116 E. Main St., Richmond
Helen Marshall and Eileen Singleton, Adms.

Golden Rule Nursing Home #1
47 S. Seventh St., Richmond
Hilda Stull, L.P.N., Adm.

Golden Rule Nursing Home #2
320-22 N. 10th St., Richmond
Hilda Stull, L.P.N., Adm.

Good Will Rest Home
500 W. Main, Cambridge City
Nell Osborne, Adm.

Hagerstown Nursing Home
801 W. Main St., Hagerstown
F. Anna Barnes, Adm.

Hilling's Nursing Home
R. R. 1, Box 237, Centerville
Betty L. Hilling, Adm.

Jenkins Hall
N. 10th St., Richmond
G. Dale Splitstone, Adm.

Mary E. Hill Nursing Home for Women, Inc.
2308 Zoar Ave., Richmond
Howard Alexander, Adm.

Pinehurst Nursing Home
R. R. 1, Centerville
Bonnie Cole, Adm.

Twin Pines Nursing Home
Main St., Economy
Elizabeth Johnson, Adm.

WELLS COUNTY

Clark Nursing Home
522 E. South St., Bluffton
Robert H. and I. Evelyn Sprinkle, Adms.

Cooper Rest Home
306 W. Wabash Ave., Bluffton
Janet E. Cooper, R.N., Adm.

Davis Nursing Home
627 S. Marion St., Bluffton
Helen Davis, Adm.

Southview Rest Home
R. R. 3, Box 306, Bluffton
Cora N. Anderson, L.P.N., Adm.

WHITE COUNTY

Archibald Memorial Home for Aged Deaf
R. R. 2, Brookston
Leroy Turner, Adm.

Monticello Nursing Home, Inc.
226 N. Illinois St., Monticello
Gerald L. Eastbrug, Adm.

WHITLEY COUNTY

Farris Nursing Home
209 W. Market St., Columbia City
Louise Farris, L.P.N., Adm.

Hillcrest Home
710 W. Ellsworth St., Columbia City
Herman O. and Edith M. Oelschlager, R.N., Adms.

Maple Hill Nursing Home
604 W. Vanburen St., Columbia City
Monroe Shepard, Adm.

South Whitley Rest Home, Inc.
306 Columbia St., South Whitley
Katherine A. Bresnahan, R.N., Adm. ◄

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Poison Control Centers in Indiana

and Adjacent States

City	Name and Address	Telephone	Director
Anderson	St. John's Hickey Memorial Hospital 127 West 19th Street	643-3391	Sister Mary, Administrator
Angola	Cameron Memorial Hospital, Inc. 416 E. Maumee	665-2141	Irene Kenyon, R.N. Roger Commager, Pharmacist
Bedford	Dunn Memorial Hospital 1616 23rd Street	BRowning 5-3331, Ext. 32	Marshall S. Wallner, Pharmacist
East Chicago	St. Catherine Hospital 4321 Fir Street	EXport 7-3080	Jack M. Troy, M.D.
Elkhart	Elkhart General Hospital 600 East Boulevard	3-5350, Ext. 224	C. Richard Yoder, M.D.
Evansville	Protestant Deaconess Hospital 600 Mary Street	HArrison 4-8011, Ext. 247	Edward J. Wolfgang, Pharmacist
Evansville	St. Mary's Hospital, Inc. 3700 Washington Avenue	GReenleaf 7-1541, Ext. 328	Kenneth Wilhelmus, M.D.
Evansville	Welborn Memorial Baptist Hospital, Inc. 412 S. E. Fourth Street	HArrison 3-3103	Richard F. Emig, Chief Pharmacist
Fort Wayne	Parkview Memorial Hospital 2200 Randalia Drive	Eastbrook 7341, Ext. 522	William O. Wissman, Pharmacist
Fort Wayne	St. Joseph Hospital 730 West Berry Street	ANthony 4121, Ext. (Emergency Room)	Miss Angeline Holbrook, R.N.
Frankfort	Clinton County Hospital 1300 S. Jackson Street	4451	Fred W. Flora, M.D.
Gary	Methodist Hospital of Gary, Inc. 1600 West 6th Avenue	TUrner 3-0491	Glen T. Dresher, R.N.

*Attention: Physicians, Hospitals and Poison Control Centers.

If you are faced with a poison emergency, and are unable to locate information on the ingredients of the "household product", in your own reference file or the nearest poison control center—remember you can call the Poison Information Center, Indiana State Board of Health as they maintain an extensive file on "Trade Name Products" due to the registration law, (Indiana Hazardous Household Product Act of 1959).

City	Name and Address	Telephone	Director
Goshen	Goshen General Hospital 200 High Park Avenue	KEystone 3-2141 (Emergency Room)	Neil Harris, M.D.
Hammond	St. Margaret Hospital 25 Douglas Street	WEstmore 2-2300	Herbert I. Arbeiter, M.D.
Indianapolis	Marion County General Hospital 960 Locke Street	MElrose 6-6331, Ext. 211 or 212	Richard W. Dyke, M.D.
Indianapolis	Methodist Hospital of Indiana, Inc. 1604 North Capitol Ave.	WAlnut 4-6411, Ext. 752, 753 or 754	Jack Hall, M.D.
Indianapolis	St. Francis Hospital North 17th Avenue Beech Grove, Indiana	STate 7-3311	H. N. Grimes, M.D.
Indianapolis	*Poison Information Center Indiana State Board of Health 1330 West Michigan Street	MElrose 3-6510 Office Hours MElrose 3-4360 After Hours, Week Ends, Holidays (If no answer on MElrose 3-6510, call MElrose 3-4360)	
Kokomo	Howard Community Hospital 3500 S. Lafountain	GL 7-6611	Don E. Gillaspy, Pharmacist
Lafayette	St. Elizabeth Hospital 1501 Hartford Street	SH 2-0221 Ext. 313 or 317	Sister M. Josita, Dir.
West Lafayette	Purdue University Student Health Center	92-2446	Loyal W. Combs, M.D.
LaGrange	LaGrange County Hospital R. R. #1	HO 3-2144	Merle V. Rawson, Pharmacist
Lebanon	Witham Memorial Hospital 1124 N. Lebanon Street	LEbanon 143 or 2447, Ext. 44	Thomas Dillon, M.D., Sponsor, Vivian Berhr, R.N., Ralph N. Clark, R.Ph.
Madison	The King's Daughters' Hospital 112 Presbyterian Ave.	1331	Ann L. Breitenbach, R.N., Director of Nurses
Marion	Marion General Hospital Wabash and Euclid Avenue	North 4-2311, Ext. 44 or 45	A. B. Snowhite, M.D.

*Informational services only

City	Name and Address	Telephone	Director
Mishawaka	St. Joseph Hospital 215 West 4th Street	BLackburn 9-1431	Abner H. Levkoff, M.D.
Muncie	Ball Memorial Hospital 2401 University Avenue	AT 4-3371 Ext. 241	Walter G. Ebert, Administrator
Portland	Jay County Memorial Hospital 505 West Arch Street	726-7131	Forrest E. Keeling, M.D.
Richmond	Reid Memorial Hospital Spring Grove	2-4091, Ext. 222	Mrs. Jessie Snyder, R.N., Head Nurse—Emergency Room
Shelbyville	William S. Major Hospital 150 W. Washington Street	EX 8-6661	Carolyn Rosenfeld, R.N.
South Bend	Memorial Hospital of South Bend Poison Control Center 615 North Michigan Street	CEntral 4-9041 Ext. 232	Harriet Hanley, M.D.
South Bend	St. Joseph Hospital 811 East Madison Street	CEntral 4-2151	Leslie M. Bodnar, M.D.
Terre Haute	Union Hospital, Inc. 1606 N. Seventh Street	CRawford 0361 Ext. (Emergency Room)	Joseph P. Gillotte, M. D.
Tipton	Tipton County Memorial Hospital 1032 S. Main Street	OSburn 5-2156	George L. Compton, M.D.

ADJACENT STATES

ILLINOIS

Chicago	Poison Control Center Presbyterian—St. Luke's Hospital 1753 W. Congress Parkway	SEeley 8-4411 Ext. 2322	Joseph Christian, M.D.

KENTUCKY

Louisville	Poison Control Center Department of Pediatrics 323 E. Chestnut St.	JUniper 2-1831	Thomas A. Courtenay, M.D.

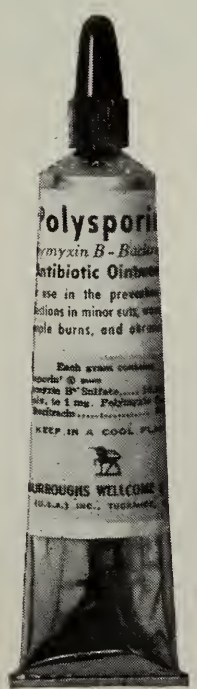
MISSOURI

St. Louis	Poison Control Center Cardinal Glennon Memorial Hospital for Children 1465 S. Grand Ave.	MOhawk 4-7222 Ext. 216	James P. King, M.D.

City	Name and Address	Telephone	Director
St. Louis	Poison Control Center St. Louis Children's Hospital 500 S. Kingshighway	FOrest 7-6880	J. Neal Middelkamp, M.D.
	OHIO		
Cincinnati	*Poison Control Center Cincinnati Academy of Medicine 320 Broadway	AV 1-6161	John A. Williams, M.D.
Columbus	Poison Control Center Children's Hospital 17th St. at Livingston Park	CLearbrook 8-9783	William O. Robertson, M.D.

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Disease	*Agent Used*	*Recommended For*	*Method of Administration*	*Type of Immunity*	*Duration of Protection*	*Booster Injection*
Cholera	Cholera Vaccine	Adults	—0.5 cc. subcutaneously followed by 1.0 cc. in 7 days.	Active	6 months	0.12-1.0 cc. according to age every six months in endemic areas.
		Children: 6 months to 2 years 3-6 years 7-10 years 11 years and older	Three subcutaneous injections given 7-10 days interval. (1) 0.06 cc.; (2) 0.12 cc.; (3) 0.12 cc. (1) 0.12 cc.; (2) 0.25 cc.; (3) 0.25 cc. (1) 0.25 cc.; (2) 0.5 cc.; (3) 0.5 cc. Adult schedule			
Diphtheria	Diphtheria Antitoxin	All early cases	Usually intramuscular if seen within 48 hours of onset. *Warning:* Test for sensitivity to horse serum. May be used intravenously in severe nasopharynx cases. Dosage dependent on degree of toxicity rather than age and weight. 10,000 units to 75,000 units.	Passive	Short	Additional antitoxin given dependent upon illness and toxicity.
Diphtheria	Diphtheria Toxoid (fluid or alum precipitated or aluminum phosphate adsorbed, for adult use)	Children older than 11 years and adults	Two intramuscular injections of 0.5 cc. each, four to six weeks apart for primary immunization or if individual has not had a booster dose of vaccine for 3 years.	(If toxoid is given then active immunity develops.)	Indefinite	0.5 cc. every year.
Diphtheria	Diphtheria-Pertussis-Tetanus alum precipitated or aluminum hydroxide (or aluminum phosphate) adsorbed diphtheria and tetanus toxoids; containing 12 protective antigenic units of vaccine per 1.5 cc. (DPT)	Children under 5 years	(1) First dose of 0.5 cc. deep intramuscularly—follow injection with 0.1-0.2 cc. air. Given 1-3 months age. (2) Second dose of 0.5 cc. deep intramuscularly one month after first dose. (3) Third dose of 0.5 cc. deep intramuscularly one month after 2nd dose. (4) If 1st dose given earlier than 3 months of age, then give fourth dose 2-3 months after series completed.	Active	Indefinite	D. P. T. booster of 0.5 cc. at 12 to 18 months and 4-5 years. After 5 years booster dose of 0.5 cc. Diphtheria Tetanus Toxoid every 3 years to age 11 years.
Diphtheria	Diphtheria Tetanus Toxoid alum precipitated or aluminum hydroxide (or aluminum phosphate) adsorbed.	Children over 5 years and up to 10 years	(1) First dose of 0.5 cc. deep intramuscularly, follow injection with 0.1-0.2 cc. air. (2) Second dose of 0.5 cc. deep intramuscularly—follow injection with 0.1-0.2 cc. air.	Active	Indefinite	Diphtheria Tetanus booster 0.25 cc. to 0.5 cc. *Caution:* Do not give to children past 10 years of age.

Diphtheria	Diphtheria Toxoid Pertussis Vaccine Tetanus Toxoid Fluid	Rapid immunization of children under 10 years	Three doses of 0.5 cc. given subcutaneously at intervals of 3-4 weeks. In face of epidemic injections may be given at one week intervals.	Active	Antigenic response lower than with the alum preparations and does not last as long.	0.5 cc. every 2 years.
Diphtheria	Diphtheria Toxoid Tetanus Toxoid Fluid	Rapid immunization under 10 years	Three doses 0.5 cc. given subcutaneously at intervals of 3-4 weeks. In face of epidemic injections may be given at intervals of one week.	Active	Antigenic response lower than with alum preparations and does not last as long.	0.5 cc. every 2 years.
Hepatitis, Infectious (Epidemic)	Immune Serum Globulin (Gamma Globulin)	All exposed in household, institution, etc.	Dosage: 0.01 cc. per pound of body weight. Given intramuscularly.	Passive	Brief	Repeat each exposure.
Influenza	Polyvalent Vaccine	Use during epidemics		Active (in 70% + immunized)	Short: 3-4 months	Repeat primary injection and/or injections annually.
		Children	Give total of 1.0 cc. in the course of one week.			
		Adults—especially all with chronic debilitating disease of heart and lungs.	1.0 cc. subcutaneously. *Warning:* Precautions must be taken in individuals sensitive to egg protein. *(Note:* There is less chance of local or systemic reaction if only 0.1 cc. is given intradermally for a total of 2 doses 7-10 days apart).			
Measles* (Rubeola)	Immune Serum Globulin (Gamma Globulin)	Complete passive immunity children under one year; children ill with chronic disease or healthy child whose siblings are ill with chronic disease	Dosage 0.2 cc. per pound of body weight given prior to 6th day after exposure. Given intramuscularly.	Passive	Very brief	Repeat each exposure.
		Incomplete immunity or modification in all other children	Dosage 0.05 cc. per pound of body weight before 6th day after exposure; if given after 6th day use dose of 0.1 cc. per pound of body weight. Given intramuscularly.	Partial passive. Child has modified disease and develops active immunity	For life if disease was modified and not prevented.	
Measles, German (Rubella)	Immune Serum Globulin (Gamma Globulin)	Pregnant females exposed during the first trimester	Dosage: 0.1 cc. per pound of body weight. Given intramuscularly.	Passive	Very brief	Repeat each exposure if pregnant.

* Measles Vaccine—The measles vaccines have just been licensed. There are two vaccines available: (1) A live attenuated vaccine. One dose of vaccine is given by intramuscular route. It is recommended that gamma globulin be administered at the same time to modify reactions to the vaccine. (2) Inactivated vaccine is given in three doses at monthly intervals. A third method of immunization is pending. This consists of two doses of killed vaccine followed by one dose of live, attenuated vaccine. Vaccines are too new to establish longevity of immunity at this time. Consult the manufacturers.

Disease	Agent Used	Recommended For	Method of Administration	Type of Immunity	Duration of Protection	Booster Injection
Meningococcic Meningitis	Sulfadiazine	Control of exposed persons in community groups Children up to 11 yrs.	0.5 m. twice daily for 2 days.	None Chemical prophylaxis only	Very brief—for one exposure only.	Repeat following each exposure.
		Adults (and children 12 yrs. or over)	1.0 gm. twice daily for 2 days.			
Mumps	Mumps Vaccine	Adults exposed to case and with negative history of having had mumps	*Warning:* Check on sensitivity to egg protein. Two injections given 5 to 10 days apart of 1.0 cc. each subcutaneously.	Active	Brief	Previously immunized persons may be given booster dose of 0.5 to 1.0 cc. subcutaneously.
Pertussis	Pertussis Vaccine saline suspended (See Double and Triple antigens under "Diphtheria")	Children during epidemic	A total of 12 N. I. H. units divided into 3 equal doses of 4 N. I. H. units (0.5 cc.) given subcutaneously at intervals of one week.	Active	Indefinite	1 year after primary series, 2 years after primary series and then every three years to 6 or 7 years of age.
	Pertussis Vaccine alum precipitated or aluminum hydroxide adsorbed (See Double and Triple antigens under "Diphtheria")	Routine immunization of infants when DPT is contraindicated	A total of 12 N. I. H. units divided into 3 equal doses of 4 N. I. H. units each (0.5 cc.) injected intramuscularly at intervals of 4 to 6 weeks.	Active	Indefinite	18 months—3-4 years. 6-7 years usually given as DPT.
		Exposure Recall		Active	Indefinite	.4 NIH units (0.5 cc.) saline suspension subcutaneously if child has not had immunization past 2 years.
Plague	Plague Vaccine—a suspension of 2000 million killed Pasteurella per milliliter	Epidemics and areas with high endemic rate. Adults: Children: 6 months-2 years 2 years-6 years 6 years-10 years	Two injections subcutaneously 7-10 days apart. First injection 0.5 cc.; second, 1.0 cc. 0.06 cc.; 0.12 cc; 0.12 cc. 0.12 cc.; 0.25 cc.; 0.25 cc. 0.25 cc.; 0.50 cc.; 0.50 cc.	Active Active	Partial protection for period of 4-6 mos. Partial protection for period of 4-6 mos.	1.0 cc. every 4 months as long as danger of epidemic exists. Booster dose for children is same as first dose of initial series.
Poliomyelitis*	Poliomyelitis (Salk) Vaccine	All Ages	Two injections each 1.0 cc. given intramuscularly at interval of 3-6 weeks. Third injection of 1.0 cc. given 7 months after second.	Active	Not known (Salk has demonstrated adequate antibodies present after 8 years)	Booster dose of 1.0 cc. recommended 8 to 12 months after 3rd dose. Additional booster doses advised if in epidemic area.

* Poliomyelitis Vaccine, oral, live, attenuated—These vaccines are licensed. No description is given in the table as their use is largely recommended for mass immunization. The Indiana State Medical Association, the Indiana State Health Officers Association and the Indiana State Board of Health in October 1962 stated there was little need for mass oral programs and recommended no new programs be initiated.

Rabies	**Rabies—hyperimmune serum 1000 units per pound of body weight Rabies Vaccine 7-14 doses**	***Licks* of abraded skin or mucosa by proven rabid, suspicious, escaped, killed or unknown animal**	**Hyperimmune serum within 24-72 hours of exposure. Follow within 24 hours with Rabies Vaccine.**	**Passive immunity from hyperimmune serum**	**Few weeks**	**Repeat initial dose hyperimmune serum, but not after beginning Rabies Vaccine series as serum will block antibody production.**
		***Bites* of healthy animal, multiple, or face or head bites**	**Hyperimmune serum. Start vaccine but stop if animal remains normal for 3 days.**	**Active immunity from rabies vaccine**	**Indefinite**	**Rabies vaccine prepared according to Semple method—should not repeat full course—one to 3 injections probably sufficient. More hazardous Egg embryo vaccine—give one injection.**
		***Bite* of healthy animal, other than head or neck**	**No treatment. If animal becomes suspicious during 14 days observation give serum and vaccine at first suspicious signs.**			
		***Bites*—animal rabid, escaped, killed, unknown or any bites by any wild animal**	**Start treatment immediately, using hyperimmune serum followed by 7-14 doses vaccine, depending upon whether single or multiple bites and location.**			
		Bat bites and exposure to bats	**Start treatment with Rabies Vaccine immediately without waiting for Laboratory Report. Bats are only animals known to occasionally survive rabies and remain carriers.**			
Rocky Mountain Spotted Fever	**Rocky Mountain Spotted Fever Vaccine**	**Not routinely recommended since advent of specific antibiotic therapy. May be used in areas of high incidence among persons of high risk.**	**Adults: 3 injections each 1.0 cc. subcutaneously or intramuscularly at intervals of one week. Children—under 10 years three injections each 0.5 cc. subcutaneously or intramuscularly at intervals of one week.**	**Active**	**One year**	**1.0 cc. booster annually**
Smallpox	**Smallpox Vaccine (Vaccinia virus)**	**Children and adults**	**Begin at 5-12 months. Administered by multiple pressure technique skin over insertion of left deltoid.**	**Active**	**Indefinite, average 3 years**	**Repeat every 4th year.**
Tetanus	**Tetanus Antitoxin**	**All cases of puncture wounds and animal bites when person has not been immunized or more than 2 years since last booster.**	***Caution:* Skin test first for serum sensitivity. Intramuscular injection of 10,000 units antitoxin.**	**Passive**	**10 days**	**Repeat with each injury. Because of hazard to horse serum active immunization with toxoid preferred.**

Disease	Agent Used	Recommended For	Method of Administration	Type of Immunity	Duration of Protection	Booster Injection
Tetanus	Tetanus Toxoid, depot (alum precipitated or adsorbed) (See Double and Triple antigens under "Diphtheria")	All	Two doses, each 0.5 cc. given intramuscularly, at least one and preferably 2-3 months interval.	Active	At least 4 years	0.5 cc. end first year, then—booster every 2-4 years. Satisfactory recall response after 10 years but is too slow in case of injury. Emergency booster if injured.
	Tetanus Toxoid, Fluid (See Double and Triple antigens under "Diphtheria")	All	Three doses, each 0.5 cc., subcutaneoulsy or intramuscularly at one month and preferably 2-3 months between doses.	Active	At least 4 years	0.5 cc. end first year, then—booster every 2-4 years. Satisfactory recall response after 10 years but is too slow in case of injury. Emergency booster if injured.
Typhoid Fever	Typhoid Vaccine Triple vaccine containing 1000 million S. typhosa and 250 million each of paratyphoid A and B per cc.	All persons living in or traveling to areas where disease is endemic or insanitary conditions exist.	*Adults* Three doses, each 0.5 cc. subcutaneously not less than 7 days or more than 28 day intervals between doses. An alternate method is: 0.1 cc.; 0.15 cc. and 0.2 cc. given intradermally not less than 7 nor more than 28 days between doses. *Children* 6 mo.-2 yr.—(1) 0.06 cc.; (2) 0.12 cc.; (3) 0.12 cc. 2 yr.- 6 yr.—(1) 0.12 cc.; (2) 0.25 cc.; (3) 0.25 cc. 6 yr.-10 yr.—(1) 0.25 cc.; (2) 0.50 cc.; (3) 0.50 cc.	Active	Indefinite—usually at least one year	Persons traveling or living in insanitary areas should receive booster of 0.1 cc. intradermally or 0.5 cc. subcutaneously annually. Children's annual booster the same dose as initial dose of each series.
Typhus Fever	Typhus Fever Vaccine	All persons traveling to or living in areas where epidemic typhus exists.	*Adults* Two doses, each 1.0 cc. at intervals of 7-10 days given subcutaneously. Allergy to egg or chicken protein only contraindication. *Children* Three doses each: 6 mos.-2 yrs.: 0.12 cc. 2 yrs.- 6 yrs.: 0.25 cc. 6 yrs.-10 yrs.: 0.50 cc.	Active	Relative 3-6 months	*Adults* Routine every 6 months dose of 1.0 cc. given subcutaneously or whenever threat of outbreak occurs. *Children* Same dose as in initial series.
Yellow Fever	Yellow Fever Vaccine* (Obtainable only at U. S. P. H. S. Hospital or Yellow Fever Immunization Depots. See footnote where obtainable in Indiana.)	All persons traveling in or through or living in endemic areas. Should receive vaccine 10 days before arrival in area.	One dose 0.5 cc. of a 1:10 dilution of concentrated vaccine, freshly prepared. Given subcutaneously. Should not be given to person ill with virus disease or at same time cowpox virus is given. Children's dose—same as adult.	Active	6 years or longer	As required at present every 6 years repeat immunization. In presence of epidemic repeat primary immunization.

*While many contraindications are listed for various biologicals it should be recognized that in the interest of brevity it was impossible to give all details. In case of doubt consult standard reference for detailed description of biological in question and/or pharmaceutical company's circular accompanying original package of biological.

All of the biologicals listed may be obtained through normal supply channels with the exception of Yellow Fever Vaccine. Because of hazards if yellow fever vaccine is improperly handled it can only be obtained from U. S. P. H. S. depots. In Indiana these depots are:

Indiana University Medical Center
1040 West Michigan Street
Indianapolis
Fridays, 11 a.m. to 12 noon CDT by appointment
Telephone: MElrose 5-8441, Ext. 441

Elkhart County Health Department
200 Harrison Street
Elkhart, Indiana
1st or 3rd Wednesday each month 2 p.m.
Telephone 26525

Physicians having patients requiring yellow fever immunization should advise person to call or write the above, as inoculations are given by appointment only on one day a week. There is a fee to cover vaccine and administration.

(Revised)

A. L. Marshall, Jr., M.D., *Director*
Division of Communicable Disease Control
Indiana State Board of Health

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Class A Narcotic Drugs

The following is a compilation of Class A Narcotic Drugs by Trade Name prepared for publication by L. C. Heustis, Executive Secretary of the Indiana Pharmaceutical Association. It is designed to aid physicians in determining the proper and legal methods of prescribing narcotics. A pharmacist is required by law to have in hand a properly completed prescription prior to the dispensing of any of the Class A narcotics. No verbal or phoned prescriptions are permitted in Class A. (As of July 1, 1964.)

Package	Class A Narcotics by Trade Name
Tab.	A.P.C. Demerol (Demerol 30 mg.)
Supp.	B&O 15A (Opium ½ gr., Belladonna ¼ gr.)
Supp.	B&O 16A (Opium 1 gr., Belladonna ¼ gr.)
	Chlor-Anodyne (Morphine Hcl. 2⅞ gr. per oz.)
	Cocaine Solutions
Solvets	Cocaine Hcl. 2¼ gr.
Amp.	Codeine Phos. ½ gr. per cc.
H.T.	Codeine Phos. ¼ gr.
H.T.	Codeine Phos. ½ gr.
H.T.	Codeine Phos. 1 gr.
D.T.	Codeine Sulf. 1 gr.
H.T.	Codeine Sulf. ⅛ gr.
H.T.	Codeine Sulf. ¼ gr.
H.T.	Codeine Sulf. ½ gr.
H.T.	Codeine Sulf. 1 gr.
T.T.	Codeine Sulf. ¼ gr.
T.T.	Codeine Sulf. ½ gr.
T.T.	Codeine Sulf. 1 gr.
	Codeine, if more than 8 grs. per fl. oz. or more than 1 gr. per dosage unit
	Demerol Solutions
Amp.	Demerol 25 mg.—½ cc.
Amp.	Demerol 50 mg.— 1 cc.
Amp.	Demerol 75 mg.—1½ cc.
Amp.	Demerol 100 mg.
Amp.	Demerol Atropine 2 cc. (Demerol 100 mg—2 cc.)
Amp.	Demerol Scopolamine 2 cc. (Demerol 100 mg—2 cc.)
Elix.	Demerol (Demerol 50 mg. per 5 cc.)
	Demerol Disp. Syr. 50 mg.—1 cc.
	Demerol Disp. Syr. 75 mg.—1 cc.
	Demerol Disp. Syr. 100 mg.—1 cc.
Tab.	Demerol 50 mg.
Tab.	Demerol 100 mg.
Vial	Demerol 50 mg. per cc.
Vial	Demerol 100 mg. per cc.
Vial	Demerol Scopolamine (Demerol 50 mg. per cc.)
Tab.	Demerol APAP (Demerol 50 mg.)
Tab.	Demerol Comp. (Demerol 25 mg.)
Tab.	Demerol Lotusate (Demerol 100 mg.)
Tab.	Dicodid 5 mg.
Amp.	Dilaudid Hcl. 1/32 gr.—1 cc.
Amp.	Dilaudid Hcl. 1/20 gr.—1 cc.
Amp.	Dilaudid Hcl. 1/16 gr.—1 cc.
Rect. Supp.	Dilaudid Hcl. 1/20 gr.
Syr.	Dilaudid (1 mg.—5 cc.)
	Dilaudid Hcl. Solutions
H.T.	Dilaudid Hcl. 1/64 gr.
H.T.	Dilaudid Hcl. 1/32 gr.
H.T.	Dilaudid Hcl. 1/20 gr.
H.T.	Dilaudid Hcl. 1/16 gr.
Vial	Dilaudid Sulf. 2 mg. per cc.
	Dionin Solutions
Amp.	Dolophine Hcl. 10 mg.—1 cc. (Methadone Hcl.)
20 cc. Amp.	Dolophine Hcl. 10 mg. per cc.
Syr.	Dolophine Hcl. (Methadone Hcl. 10 mg. per 30 cc.)
Tab.	Dolophine Hcl. 5 mg.
Tab.	Dolophine Hcl. 7.5 mg.
Tab.	Dolophine Hcl. 10 mg.
Tab.	Donnagesic #2 (Codeine Phos. 1½ gr.)
	Dover's Po. N.F. (Po. Ipecac and Opium)
H.T.	H.M.C. #1 (Morphine HBr. ¼ gr.)
H.T.	H.M.C. #2 (Morphine HBr. ⅛ gr.)
	Hycodan Po.
10 cc. Vial	Hymorphan Hcl. 2 mg. per cc.

Package	Class A Narcotics by Trade Name
10 cc. Vial	Hymorphan Hcl. 2 mg. per. cc. Atropine Sulf. 0.25 mg. per cc.
Amp.	Leritine 1 cc., 25 mg. per cc.
Amp.	Leritine 2 cc., 25 mg. per cc.
Tab.	Leritine 25 mg.
30 cc. Vial	Leritine 25 mg. per cc.
Amp.	Levo-Dromoran 2 mg.—1 cc.
Tab.	Levo-Dromoran 2 mg.
10 cc. Vial	Levo-Dromoran 2 mg. per cc.
Tubex	Meperidine Hcl. 50 mg.—1 cc.
Tubex	Meperidine Hcl. 75 mg.—1 cc.
Tubex	Meperidine Hcl. 100 mg.—1 cc.
Cap.	Mepergan
Cap.	Mepergan Fortis
Tubex	Mepergan 25—50 mg. per 2 cc.
10 cc. Vial	Mepergan 25—25 mg.—1 cc.
Tubex	Mepergan 50—50 mg.—1 cc.
10 cc. Vial	Mepergan 50—50 mg.—1 cc.
100 Tab.	Mercodinone
20 cc. Vial	Methadone Hcl. 10 mg. per cc.
30 cc. Vial	Methadone Hcl. 10 mg. per cc.
Syr.	Methajade
	Morphine Acetate
Elix.	Morphine Hcl. 1 gr. per fl. oz.
	Morphine Solutions
Amp.	Morphine Sulf. ¼ gr. per cc.
Amp.	Morphine Sulf. ¼ gr., Atropine Sulf. 1/150 gr. per cc.
H.T.	Morphine Sulf. ⅛ gr.
H.T.	Morphine Sulf. 1/6 gr.
H.T.	Morphine Sulf. ¼ gr.
H.T.	Morphine Sulf. ½ gr.
H.T.	Morphine Sulf. 1 gr.
H.T.	Morphine Sulf. ¼ gr., Atropine Sulf. 1/150 gr.
T.T.	Morphine Sulf. ¼ gr.
Amp.	Nisentil Hcl. 40 mg.—1 cc.
Amp.	Nisentil Hcl. 60 mg.—1 cc.
Vial	Nisentil Hcl. 60 mg. per cc.
Tab.	Nodalin (Methadone Hcl. 2.5 mg.)
†*Tab.*	*Nucodan 5 mg.*
Amp.	Numorphan Hcl. 1 cc. (1.5 mg per cc.)
Amp.	Numorphan Hcl. 2 cc. (1.5 mg. per cc.)
10 cc. Vial	Numorphan Hcl. (1.5 mg. per cc.)
Supp.	Numorphan Hcl. 2 mg.
Supp.	Numorphan Hcl. 5 mg.
	Opium Po.
	Opium Po. Extract
Tab.	*Numorphan Hcl. 10 mg.*
Rect. Supp.	Opium 1 gr. Belladonna ¼ gr.
Tr.	Opium U.S.P. Deod.
	Pantopon All
	Papine
Cap.	*Percobarb 5 mg.*
Cap.	*Percobarb-Demi 2.5 mg.*
Tab.	*Percodan 5 mg.*
Tab.	*Percodan-Demi 2.5 mg.*
Amp.	Prinadol 2 mg. 1 cc.
10 cc. Vial	Prinadol 2 mg. per cc.
Amp.	Spasmalgin 1 cc. (Pantopon 1/6 gr. Papaverine Hcl. 1/3 gr. 1 cc.)
Tab.	Spasmalgin (Pantopon 1/6 gr. Papaverine Hcl. 1/3 gr.)
Cap.	Synalgos DC (Dihydrocodeine 16 mg.)

† All italicized drugs have been added this year.

*The 4 Narcotic Classes**

The Karsten narcotic law, which became effective January 1, 1961 has resulted in the division of all narcotic drugs as follows:

CLASS A—This is the old, original basic narcotic drug class, used to control products that have addiction liability. Preparations in this class are subject to the strictest controls all the way down the line. Examples would include Cocaine, Dolophine, Demerol, Morphine, Pantopon, etc. They cannot be dispensed without a written prescription, and of course, cannot be refilled.

CLASS B—This group was established a few years ago when Congress authorized oral prescriptions for a limited group of narcotic drug-preparations. Included in this class are: Apomorphine, A.S.A. and Codeine Compounds, Copavin, Cotarnine, Dihydrocodeinone, Narcotine and Narceine. Dihydrocodeinone was transferred to this group from Class X and is not longer exempt.

CLASS X—This is the category of so-called exempts—narcotic preparations

Continued

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NARCOTIC CLASSES

Continued

found by the federal narcotics bureau to have only a slight addiction liability. Narcotic form order is not required.

CLASS M—This is the new control group, created under the Karsten law. Drugs in this class have no addiction liability, or less liability than those in Class X. Narcotic order not required. This class was created by transferring preparations into it from Class B: combinations of non-narcotic ingredients with narcotine, papaverine, narceine, or cotarnine. However, pure narcotine, papaverine, narceine, cotarnine, and their salts remain as Class B drugs, to be dispensed only on prescription.

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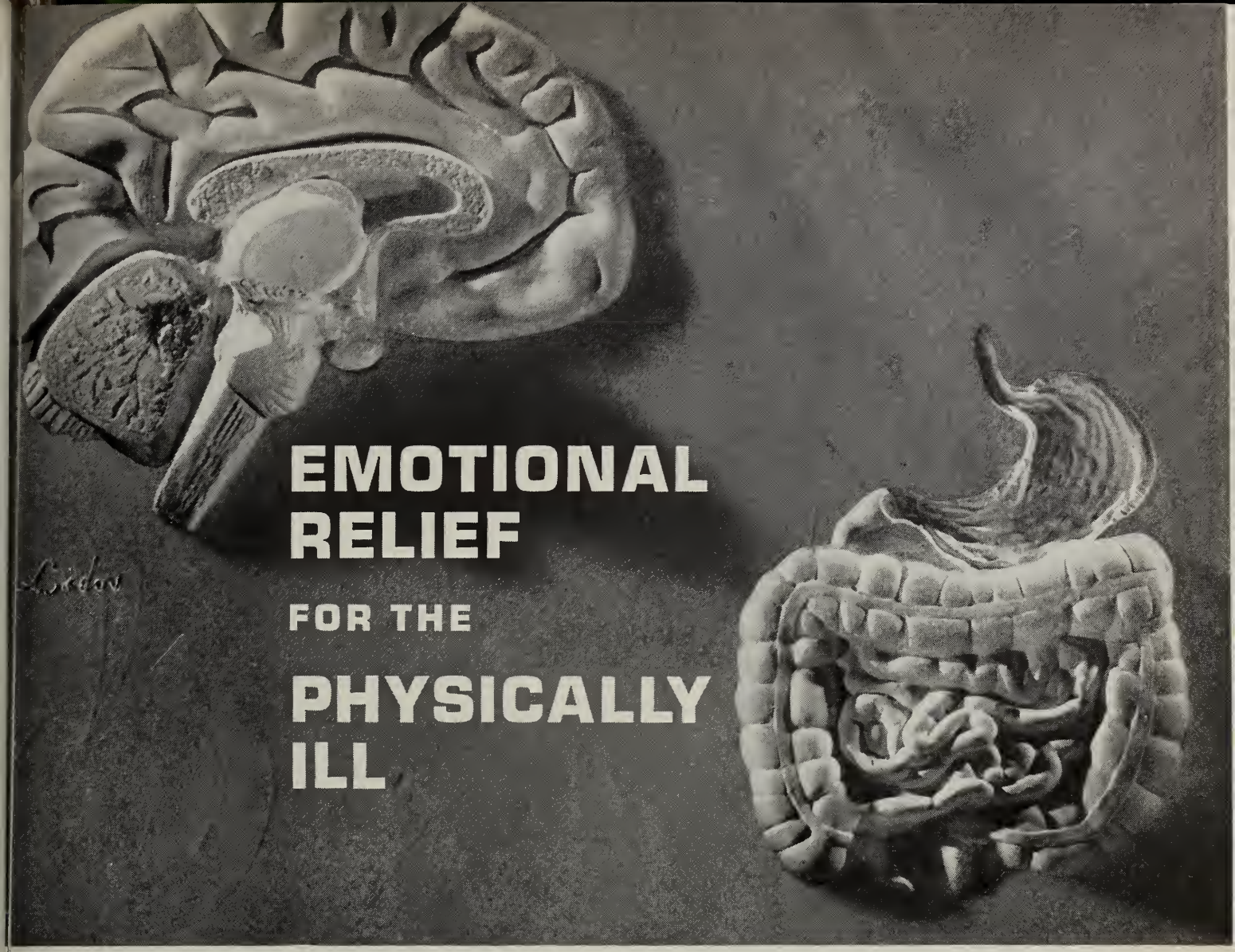


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Complete product information available in the product package, and to physicians upon request.

Usual adult dosage: One 400 mg. capsule or two 200 mg. capsules at breakfast; repeat with evening meal.

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Deaths of Indiana Physicians in 1963

Compiled by James B. Maple, M.D., Necrologist

(M) Member ISMA, (S) Senior Member, (R) Retired, (H) Honorary

Name	Age	Date of Death	Address	Cause of Death
Sprogis, George, Sr.	72	Jan. 14	Hiram	Rheumatic heart disease.
Sensenich, Roscoe L. (H) (R)	80	Jan. 18	South Bend	Acute myocardial infarction.
Densford, Will L.	79	Jan. 18	Indianapolis	Generalized arteriosclerosis.
Davis, Parvin M. (M)	66	Jan. 30	New Albany	Bronchopneumonia.
Badders, Ara C. (S) (R)	72	Feb. 2	Portland	Congestive heart failure. Arteriosclerosis.
Engleman, Harry K. (S)	83	Feb. 5	Georgetown	Metastatic carcinoma of the stomach.
Ellison, Alfred (M) (R)	66	Feb. 12	South Bend	Cancer of the lungs and trachea.
Harrod, Cecil G.	78	Feb. 15	Columbus	Myocardial infarction.
Lowery, George E. (M)	54	Feb. 19	Butlerville	Overdose of barbiturates.
Dunbar, Colin V. (S)	80	Feb. 21	Indianapolis	Cardiac arrest. Arteriosclerotic heart disease.
Connell, Paul S. (M)	62	Feb. 23	Plymouth	Coronary thrombosis. Arteriosclerosis.
Briggs, John J.	80	Mar. 2	Indianapolis	Coronary thrombosis. Arteriosclerotic heart disease.
Cooksey, Thomas L. (S)	92	Mar. 6	Crawfordsville	Chronic interstitial nephritis.
Kopp, Otis A. (M)	68	Mar. 6	Anderson	Coronary occlusion. Arteriosclerotic heart disease. Prostatic carcinoma.
Robinette, Mary E. (R)	81	Mar. 8	Indianapolis	Generalized arteriosclerosis.
Marshall, Lloyd C. (S)	75	Mar. 17	Mt. Summit	Chronic pyelonephritis. Diabetes mellitus.
Higbee, Paul (S) (R)	80	Mar. 18	Sullivan	Bronchopneumonia. Arteriosclerotic heart disease
Ensminger, Leonard A. (S) (R)	84	April 2	Indianapolis	Pneumonia. Pancreatic carcinoma.
Wiggins, Dulania (S) (R)	88	April 4	New Castle	Coronary occlusion.
Schenck, Faye O. (S) (R)	84	April 6	Crawfordsville	Coronary occlusion. Arteriosclerosis. Diabetes mellitus.
Levering, Guy P. (S)	86	April 19	Lafayette	Cerebral thrombosis. Arteriosclerotic heart disease.
Norton, Thomas J.	93	April 23	Grammer	Pneumonia. Myeloid leukemia.
Lang, Joseph E. (M)	52	April 30	South Bend	Cerebral hemorrhage. Ruptured cerebral aneurysm.
Kalavros, Michael H.	73	May 11	Gary	Myocardial infarction.
Franklin, Philip L. (M)	51	May 19	Gary	Medullary compression. Metastatic tumor of pons. Adrenal gland carcinoma.
Powell, Robert A.	51	May 21	Terre Haute	Acute myocardial infarction. Arteriosclerotic heart disease.
Wade, Alfred A. (S) (R)	80	May 24	Howe	Cerebral arteriosclerosis.
Bivin, James H. (M)	41	May 29	Mooresville	Coronary occlusion.
Slapak, Wilhelmina	78	May 30	Hammond	Bronchopneumonia. Carcinomatosis. Carcinoma of the breast.
Howell, Robert D. (M)	57	June 2	Indianapolis	Squamous cell carcinoma of the lungs.
Venable, George L. (S)	71	June 6	North Manchester	Advanced carcinomatosis. Primary prostatic carcinoma.
Murphy, Maurice G. (S)	77	June 7	Morgantown	Acute cardiac failure.
Taylor, William R. (S)	72	June 13	Richmond	Arteriosclerotic heart disease.
Michael, Herman C. (R)	89	June 16	Fort Wayne	Rupture of aortic aneurysm.
Jackson, Frederick E. (S)	85	June 18	Indianapolis	Carcinoma of the colon.
Teegarden, Joseph A. (S)	82	June 22	East Chicago	Acute cardiac insufficiency. Arteriosclerotic heart disease. Generalized arteriosclerosis.
Clevenger, Joseph H. (M)	61	June 25	Muncie	Cerebrovascular accident. Myocardial infarction.
McClellan, John B. (M)	51	June 25	Muncie	Massive gastrointestinal hemorrhage. Ruptured gastroesophageal varices.

Name	Age	Date of Death	Address	Cause of Death
How, John T. (S)	89	June 26	Lakeville	Left ventricular failure. Pneumonia.
Tucker, Oral A. (M)	77	June 28	Daleville	Acute myocardial infarction.
Arthur, Maude (M) (S)	84	June 28	Washington	Myocardial infarction. Arteriosclerotic heart disease.
Stimson, Harry R. (M)	61	June 30	Gary	Coronary occlusion.
Leonard, Henry S. (S)	88	July 3	Indianapolis	Cardiac decompensation. Arteriosclerosis.
Newcomer, Frank U.	66	July 3	Elwood	Coronary occlusion. Coronary arteriosclerosis.
Ramos, Alfonso F. (M)	46	July 8	Gary	Coronary occlusion. Myocardial infarction.
Wood, William H. (R)	89	July 8	Fort Wayne	Pulmonary infarction. Thrombosis left femoral vein.
Jewell, Earl B. (S) (R)	81	July 11	Logansport	Myocardial infarction.
Bartholomew, Mary L. (M)	64	July 12	Goshen	Adenocarcinoma of ovary.
Balch, James F. (M)	60	July 18	Indianapolis	Acute coronary occlusion.
Cardenas, Mario	57	July 18	Marion	Internal hemorrhage. Auto accident.
Snyder, Earl R. (S) (R)	83	Aug. 2	Troy	Myocardial infarction. Coronary arteriosclerosis.
McCoy, George E. (M)	45	Aug. 9	Muncie	Injuries sustained in private plane wreck.
Thimlar, J. Wiley (S)	79	Aug. 12	Fort Wayne	Coronary thrombosis with myocardial infarction.
Portteus, Walter L. (M)	63	Aug. 18	Franklin	Pulmonary carcinoma with cerebral metastasis.
Tennis, George T. (M)	57	Aug. 21	Greencastle	Cerebral embolism. Metastatic adenocarcinoma of the liver.
Burkle, John C. (S)	82	Sept. 1	Lafayette	Acute peritonitis. Ruptured diverticulum of sigmoid colon.
Ridgeway, Ora W. (S) (R)	84	Sept. 6	Indianapolis	Myocardial insufficiency. Arteriosclerotic heart disease.
Yarian, Henry O.	90	Sept. 14	Auburn	Cardiovascular respiratory disease.
Miller, Arthur H. (S)	85	Sept. 16	Russiaville	Cerebral hemorrhage. Generalized arteriosclerosis.
Hoppenrath, Wesley M.	69	Sept. 16	Elwood	Uremia. General metastatic carcinoma. Carcinoma of left lung.
Atchison, Kenneth C. (S)	76	Sept. 16	Rockport	Arteriosclerosis.
Bullard, Mattie J. (M) (R)	63	Oct. 3	Gary	Cerebrovascular accident.
Elliott, John C. (S) (R)	83	Oct. 21	Lawrenceburg	Cerebrovascular accident. Generalized arteriosclerosis.
Norris, Howard L. (R)	71	Oct. 22	Mooresville	Acute coronary failure. Stokes-Adams syndrome.
Perlov, Sylvan H. (M)	36	Oct. 22	Indianapolis	Barbiturate poisoning.
Gwin, Merle D. (S) (R)	84	Oct. 24	Rensselaer	Perirenal abscess. Cholangitis. Cholelithiasis.
Arnold, John B.	72	Oct. 26	Indianapolis	Carcinoma of the pancreas.
Staten, Jesse C. (M)	50	Nov. 1	Indianapolis	Died in explosion of State Fair Coliseum.
McClung, Marshall L.	68	Nov. 1	Indianapolis	Skull fracture and cerebral hemorrhage in State Fair Coliseum explosion.
Rothrock, Milson W.	86	Nov. 3	Evansville	Prostatic carcinoma.
Combs, Pearl B. (S) (R)	77	Nov. 4	Evansville	Subdural hemorrhage. Auto accident.
Hill, Harold D. (M)	48	Nov. 9	Richmond	Cerebral hemorrhage.
Mendenhall, Clarence D. (R)	66	Nov. 11	Indianapolis	Acute myocardial infarction. Generalized arteriosclerosis.
Billman, Beryl I.	70	Nov. 16	New Trenton	Infarction, left cerebral hemisphere.
Klos, Stanley J. (M)	39	Nov. 25	Valparaiso	Secobarbital poisoning.
Tully, John A. (S)	87	Dec. 6	New Castle	Arteriosclerotic heart disease.
Weaver, Timothy M. (S)	92	Dec. 7	Brazil	Cerebrovascular accident. Cerebral arteriosclerosis.
Barclay, Irvin C. (M) (R)	73	Dec. 10	Evansville	Pneumonitis.
Tindall, Paul R. (S)	75	Dec. 12	Shelbyville	Coronary occlusion.
Barnett, Ralph E. (M)	54	Dec. 19	Peru	Ruptured abdominal aortic aneurysm.

Name	Age	Date of Death	Address	Cause of Death
Leech, John (R)	71	Dec. 20	Indianapolis	Cerebral arteriosclerosis. Generalized arteriosclerosis.
Davis, John C. (S)	79	Dec. 24	Logansport	Coronary occlusion. Generalized arteriosclerosis.
Hillman, William H. (S)	89	Dec. 25	South Bend	Bronchopneumonia.
Harold, Norris E. (S) (R)	92	Dec. 29	Indianapolis	Hemiplegia. Arteriosclerosis.
Segar, Louis H. (S) (R)	73	Dec. 29	Indianapolis	Leukemia. Parkinson's disease.

SCIENTIFIC EXHIBIT APPLICATION FORM

Committee on Scientific Exhibits
Indiana State Medical Association
3935 N. Meridian Street
Indianapolis 8, Indiana

Please send me an application form for a Scientific Exhibit at the ISMA Annual Convention, October 13-15, 1964, Murat Temple, Indianapolis, Indiana.

I propose to exhibit_____

Name_____

Address_____

City_____

State_____

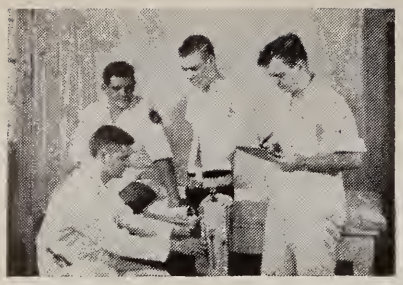
Presidents of ISMA Since Its Organization

Medical Convention	Elected	Served
*Livingston Dunlap, Indianapolis	1849	1849
Medical Society		
*William T. S. Cornett, Versailles	1849	1850
*Ashahel Clapp, New Albany	1850	1851
*George W. Mears, Indianapolis	1851	1852
*Jeremiah H. Brower, Lawrenceburg	1852	1853
*Elizur H. Deming, Lafayette	1853	1854
*Madison J. Bray, Evansville	1854	1855
*William Lomax, Marion	1855	1856
*Daniel Meeker, LaPorte	1856	1857
*Talbot Bullard, Indianapolis	1857	1858
*Nathan Johnson, Cambridge City	1858	1859
*David Hutchinson, Mooresville	1859	1860
*Benjamin S. Woodworth, Ft. Wayne	1860	1861
*Theophilus Parvin, Indianapolis	1861	1862
*James F. Hibberd, Richmond	1862	1863
*John Sloan, New Albany	1863	----
*John Moffet (acting), Rushville	1863	1864
*Samuel L. Linton, Columbus	1864	----
*Wilson Lockhart (acting), Danville	1864	1865
*Myron H. Harding, Lawrenceburg	1865	1866
*Vierling Kersey, Richmond	1866	1867
*John S. Bobbs, Indianapolis	1867	1868
*Nathaniel Field, Jeffersonville	1868	1869
*George Sutton, Aurora	1869	1870
*Robert N. Todd, Indianapolis	1870	1871
*Henry P. Ayres, Ft. Wayne	1871	1872
*Joel Pennington, Milton	1872	1873
*Isaac Casselberry, Evansville	1873	----
*Wilson Hobbs (acting), Knightstown	1873	1874
*Richard E. Houghton, Richmond	1874	1875
*John H. Helm, Peru	1875	1876
*Samuel S. Boyd, Dublin	1876	1877
*Luther D. Waterman, Indianapolis	1877	1878
*Louis Humphreys, South Bend	1878	----
*Benj. Newland (acting), Bedford (v.p.)	1878	1879
*Jacob R. Weist, Richmond	1879	1880
*Thomas B. Harvey, Indianapolis	1880	1881
*Marshall Sexton, Rushville	1881	1882
*William H. Bell, Logansport	1882	1883
*Samuel E. Mumford, Princeton	1883	1884
*James H. Woodburn, Indianapolis	1884	1885
*James S. Gregg, Ft. Wayne	1885	1886
*General W. H. Kemper, Muncie	1886	1887
*Samuel H. Charlton, Seymour	1887	1888
*William H. Wishard, Indianapolis	1888	1889
*James D. Gatch, Lawrenceburg	1889	1890
*Gonsolvo C. Smythe, Greencastle	1890	1891
*Edwin Walker, Evansville	1891	1892
*George F. Beasley, Lafayette	1892	1893
*Charles A. Daugherty, South Bend	1893	1894
*Elijah S. Elder, Indianapolis	1894	----
*Charles S. Bond (acting), Richmond	1894	1895
*Miles F. Porter, Ft. Wayne	1895	1896
*James H. Ford, Wabash	1896	1897
*William N. Wishard, Indianapolis	1897	1898
*John C. Sexton, Rushville	1898	1899

Medical Society	Elected	Served
*Walker Schell, Terre Haute	1899	1900
*George W. McCaskey, Ft. Wayne	1900	1901
*Alembert W. Brayton, Indianapolis	1901	1902
*John B. Berteling, South Bend	1902	1903
*Jonas Stewart, Anderson	1903	1904
*George T. MacCoy, Columbus	1904	1905
*George H. Grant, Richmond	1905	1906
*George J. Cook, Indianapolis	1906	1907
*David C. Peyton, Jeffersonville	1907	1908
*George D. Kahlo, French Lick	1908	1909
*Thomas C. Kennedy, Shelbyville	1909	1910
*Frederick C. Heath, Indianapolis	1910	1911
*William F. Howat, Hammond	1911	1912
*A. C. Kimberlin, Indianapolis	1912	1913
*John P. Salb, Jasper	1913	1914
*Frank B. Wynn, Indianapolis	1914	1915
*George F. Keiper, Lafayette	1915	1916
*John H. Oliver, Indianapolis	1916	1917
*Joseph Rilus Eastman, Indianapolis	1917	1918
*William H. Stemm, North Vernon	1918	1919
*Charles H. McCully, Logansport	1919	1920
*David Ross, Indianapolis	1920	1921
*William R. Davidson, Evansville	1921	1922
*Charles H. Good, Huntington	1922	1923
*Samuel E. Earp, Indianapolis	1923	1924
*Eldridge M. Shanklin, Hammond	1924	1925
Medical Association	**Elected**	**Served**
*Charles N. Combs, Terre Haute	1925	1926
*Frank W. Cregor, Indianapolis	1926	1927
George R. Daniels, Marion	1926	1928
*Charles E. Gillespie, Seymour	1927	1929
*Angus C. McDonald, Warsaw	1928	1930
*Alois B. Graham, Indianapolis	1929	1931
Franklin S. Crockett, Lafayette	1930	1932
*Joseph H. Weinstein, Terre Haute	1931	1933
*Everett E. Padgett, Indianapolis	1932	1934
*Walter J. Leach, New Albany	1933	1935
*Roscoe L. Sensenich, South Bend	1934	1936
*Edmund D. Clark, Indianapolis	1935	1937
Herman M. Baker, Evansville	1936	1938
*Edmund M. Van Buskirk, Ft. Wayne	1937	1939
Karl R. Ruddell, Indianapolis	1938	1940
*Albert M. Mitchell, Terre Haute	1939	1941
Maynard A. Austin, Anderson	1940	1942
*Carl H. McCaskey, Indianapolis	1941	1943
*Jacob T. Oliphant, Farmersburg	1942	1944
*Neslen K. Forster, Hammond	1943	1945
*Jesse E. Ferrell, Fortville	1944	1946
*Floyd T. Romberger, Lafayette	1945	1947
*Cleon A. Nafe, Indianapolis	1946	1948
Augustus P. Hauss, New Albany	1947	1949
*C. S. Black, Warren	1948	1950
*Alfred Ellison, South Bend	1949	1951
*J. William Wright, Indianapolis	1950	1952
Paul D. Crimm, Evansville	1951	1953
Wm. Harry Howard, Hammond	1952	1954
*Walter L. Portteus, Franklin	1953	1955

* Deceased.

Continued



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Certified Prosthetists from the various HANGER offices have attended courses on Upper- and Lower-Extremity Prosthetics ensuring that HANGER Clients receive the best Prosthetic Service possible. The courses are approved by the American Board for Certification and given at the U. of California at Los Angeles, Northwestern U. and at New York U., in cooperation with the Prosthetic Research Board of the National Academy of Sciences. The use of the Adjustable Leg, the Patellar-Tendon Bearing Below Knee Prosthesis, and the "quadrilateral socket" were features of a recent series of intensive courses. The curriculum was centered around the Clinical Team (illustrated) usually composed of a physician, a prosthetist and a therapist and concerned with the integrated handling of each amputee case. Thus, doctors, interested in Prosthetics can be assured that HANGER Prosthetists are fully acquainted with the latest prosthetic methods.

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ISMA PRESIDENTS

Medical Association	Elected	Continued Served
Walter U. Kennedy, New Castle	1954	1956
Elton R. Clarke, Kokomo	1955	1957
M. C. Topping, Terre Haute	1956	1958
Kenneth L. Olson, South Bend	1957	1959
Earl W. Mericle, Indianapolis	1958	1960
Guy A. Owsley, Hartford City	1959	1961
*Harry R. Stimson, Gary	1960	1962
Maurice E. Glock	1961	1963

* Deceased.

Type E Botulism Antitoxin

The Public Health Service is stockpiling antitoxin to be reserved for use against type E botulism. It will be stored at PHS Communicable Disease Center, Atlanta, Georgia, which will be on 24-hour call for emergency use.

The CDC emergency number is Area Code 404, telephone 634-2561.

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Constitution and Bylaws of the Indiana State Medical Association

CONSTITUTION

ARTICLE I.—NAME OF THE ASSOCIATION

The name and title of this organization shall be the Indiana State Medical Association.

ARTICLE II.—PURPOSE OF THE ASSOCIATION

The purposes of this Association shall be to federate and bring into one compact organization the medical profession of the State of Indiana, and to unite with similar societies of other states to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; to protect its members against imposition; and to enlighten and direct public opinion in regard to the great problems of medical care, and public health, so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life.

ARTICLE III.—COMPONENT SOCIETIES

Component societies shall consist of those county medical societies which hold charters from this Association.

ARTICLE IV.—COMPOSITION OF THE ASSOCIATION

Section 1.—This Association shall consist of Active Members, Associate Members, Senior Members and Honorary Members.

Sec. 2.—*Active Members.*—The active members of this Association shall be the members of the component county medical societies, and no county medical society shall grant active membership therein on a basis that does not include membership in the Indiana State Medical Association.

Sec. 3.—*Associate Members.*—Members of the Indiana State Dental Association in good standing are, by virtue of their membership therein, made associate members of the Indiana State Medical Association.

Sec. 4.—*Senior Members.*—Senior members shall be physicians of the State of Indiana who have attained the age of seventy years and have held membership in the Indiana State Medical Association for twenty years or more, and who, upon their application, have been certified to the Executive Secretary as eligible for such membership by the county societies of which they are members. Eligibility to senior status shall begin the year after the member reaches the age of seventy.

All members who, previous to the adoption of this amendment to the constitution, were certified as honorary members on the basis of the above qualifications, shall hereafter be classified as senior members.

Sec. 5.—*Honorary Members.*—Honorary members shall consist of teachers, scientists and others who have rendered highly meritorious service to the profession of medicine, and of physicians and surgeons of distinction, upon whom the Association may, through vote of the House of Delegates, desire to confer such membership as a special honor.

Sec. 6.—*Rights and Privileges of Members*—Active members and senior members shall have the same rights and privileges except as follows:

a. Senior members shall not be required to pay membership dues in the State Association.

b. If senior members desire to receive THE JOURNAL of the State Association, they shall pay the regular subscription price therefor.

c. Honorary members hereafter elected shall hold such membership as an honor and distinction and shall have the right to attend meetings of the Association. They shall have the privilege of participating in discussions but shall have no right to vote or to hold office. They shall not be required to pay membership dues in the State Association.

ARTICLE V.—HOUSE OF DELEGATES

The House of Delegates shall be the legislative and business body of the Association and shall consist of (1) Delegates elected by the component county societies; (2) the Councilors; and (3) the ex-presidents of the Indiana State Medical Association. The following shall be *ex officio* members: the President, the President-elect, the Executive Secretary, the Treasurer of this Association, and the delegates to the American Medical Association, all without power to vote, except in case of a tie vote, when the President or person presiding shall cast the deciding vote.

ARTICLE VI.—COUNCIL

The Council shall consist of (1) the Councilors, and (2) *ex officio* the President, President-elect, and Treasurer with power to vote. Besides its duties mentioned in the Bylaws, it shall constitute the Board of Trustees of this organization, having full charge and control of all the property of the Association. It shall have full authority and power of the House of Delegates between sessions of the House of Delegates, except that it

shall not make changes in the laws governing the Association nor exercise legislative functions, except as stated in the Bylaws, and at all times shall be the finance committee of the Association. Seven Councilors shall constitute a quorum.

ARTICLE VII.—SECTIONS AND DISTRICT SOCIETIES

The House of Delegates may provide for a division of the scientific work of the Association into appropriate sections; and for the organization of such Councilor District Societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component county societies. Councilor districts shall be defined by the House of Delegates.

ARTICLE VIII.—CONVENTION AND MEETINGS

Section 1.—The Association shall hold an Annual Convention during which there shall be held such general and section meetings as the Association through its duly constituted officers and committees may provide for.

Sec. 2.—The House of Delegates shall select the place two years in advance for holding the Annual Convention. The time for the convention shall be fixed by the Council, and the Council shall have the power also to change the place for holding the convention where conditions may create difficulties in holding a successful convention at the place designated by the House of Delegates.

Sec. 3.—Special meetings of either the Association or the House of Delegates shall be called by the President on petition of twenty delegates or fifty members.

ARTICLE IX.—OFFICERS

Section 1.—The officers of this Association shall be a President, a President-elect, an Executive Secretary, a Treasurer, and thirteen Councilors, each of whom shall be a member, except the Executive Secretary, who need not necessarily be either a physician or a member.

Sec. 2.—The officers, except the Councilors and the Executive Secretary, whose election has been provided for hereinafter, shall be elected annually. The terms of elected Councilors shall be for three years and approximately one-third of the number shall be elected annually. No Councilor shall be eligible to serve longer than two consecutive three-year terms, effective with the beginning of his next election following the adoption of this amendment.

All of these officers shall serve until their successors are elected and installed. Provided, that if any elected Councilor fails, without reason acceptable to the Council, in any one calendar year to attend a majority of the meetings of the Council, he shall thereby cease to be a Councilor, and the Executive Secretary shall thereupon take action in accordance with Section 4 of this article.

Sec. 3.—The officers of this Association with the exception of the Executive Secretary shall be elected by the House of Delegates as the first order of business of the last day of the Annual Convention, and no person shall be elected to any such office who has not been an active member of the Association for the preceding two years.

Sec. 4.—The Councilors shall be elected by the respective district societies. If any district fails to meet and elect its Councilor by the time of expiration of the incumbent's term of office, the Executive Secretary of the Association shall cause a special meeting to be called by said district society for the purpose of such election.

Sec. 5.—Each Councilor district shall elect an alternate Councilor whose term of office shall be the same as the Councilor, namely three years. The alternate Councilor shall be elected in a year during which there is no Councilor elected.

The duties of the alternate Councilor shall be:

1. To represent the Councilor district in the absence of the regularly elected Councilor.

2. To vote only in the absence of the regularly elected Councilor either in the House of Delegates or in Council meetings where he represents the regularly elected Councilor.

3. The alternate Councilor shall not have the power of discussion if the regularly elected Councilor is present.

Sec. 6.—Any officer may be removed from office after a hearing before the Council, on thirty days' notice, on charges in writing, upon a vote of three-fourths of the members of the Council.

Sec. 7.—In event of the death, resignation, removal, or disability of the President, the President-elect shall succeed to the presidency. In the event of the death, disability, resignation or removal of both the President and the President-elect, the chairman of the Council shall become President pro tem and as such shall, within a period of sixty days, call a special session of the members of the House of Delegates for the purpose of electing members to fill these vacancies, who shall serve until the next regular meeting of the House of Delegates, at which time both a President and a President-elect shall be elected, both of whom shall take office immediately upon their election.

Sec. 8.—A vacancy in the office of Treasurer shall be filled by an election by the Councilors at the next regular meeting of the Council following the occurrence of such vacancy.

Sec. 9.—In the event of a vacancy occurring from any cause, except expiration of the term of office, in the office of any district councilor, the duly elected alternate councilor from the same district shall succeed to the office of councilor in that district for the unexpired term of said councilor.

In the event vacancies occur in any councilor

district in the offices of both councilor and alternate councilor, the vacancies shall be filled by an election by the members of the association within the councilor district in which such vacancies occur. A call for such elections shall be issued by the Executive Secretary of the State Association following conference with the officers of the district organization. The call shall state the time and place of holding the election and shall be sent registered mail to the county secretary as filed in the State secretary's office of each component society within the district. Such call shall be mailed within ten days after the State secretary has learned of the vacancies. The election may be held at a special or regular meeting in which other business than the election may be transacted. Such election shall be held within fifteen days after the secretary of the State Association shall have mailed such call.

Sec. 10.—None of the officers shall receive compensation except the Executive Secretary, who shall be employed by the Council, and the Council shall fill any vacancy in that office.

ARTICLE X.—RECIPROCITY OF MEMBERSHIP WITH OTHER STATE SOCIETIES

In order to broaden professional fellowship, this Association is ready to arrange with other State Medical Associations for an interchange of certificates of membership so that members moving from one state to another may avoid the formality of re-election.

ARTICLE XI.—INCOME AND EXPENSES

Funds for carrying on the activities of this Association shall be raised by the following means:

a. Membership dues to be collected by the component county societies in connection with the dues for such component societies. The amount of the dues of each component society shall be fixed by the society itself; and the amount of dues for this Association shall be fixed from time to time by the House of Delegates.

b. Voluntary contributions.

c. Revenues derived from the Association's publications.

d. Any other manner approved by the House of Delegates.

Funds may be appropriated by the House of Delegates to defray the expenses of the Association, for publications, and for such other purposes as will promote the welfare of the profession. All motions and resolutions appropriating funds must be referred to the Council for approval before final action is taken thereon.

ARTICLE XII.—REFERENDUM

Section 1.—A General Meeting of the Association may, by a two-thirds vote of the members present, order a general referendum on any question pending before the House of Delegates, and when so ordered the House of Delegates shall submit such question to the members of the Association, who may vote by mail or in person, and if the members voting shall comprise a majority of all members of the Association, a majority of such vote shall determine the question and be binding on the House of Delegates.

Sec. 2.—The House of Delegates may, by a two-thirds vote of its own members, submit any question before it to a general referendum, as provided in the preceding section, and the result shall be binding on the House of Delegates.

ARTICLE XIII.—THE SEAL

The Association shall have a common Seal, with power to break, change or renew the same at pleasure.

ARTICLE XIV.—AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates present at any Annual Convention, provided that such amendment shall have been presented in open meeting at the previous Annual Convention, and that it shall have been published twice during the year in THE JOURNAL of this Association.

BYLAWS

CHAPTER I.—MEMBERSHIP

Section 1.—The term "Member" as used in these Bylaws unless otherwise indicated shall mean both active and senior members of component county medical societies who hold either the Degree of Doctor of Medicine or Bachelor of Medicine.

Sec. 2.—Any physician who is a member in good standing of a component county society and who has paid to this Association his annual dues is a member in good standing of the Indiana State Medical Association, provided, however, that he is a citizen of the United States of America, or has filed his declaration of intention of becoming a citizen and his first citizenship papers are in full force and effect.

Sec. 3.—No person whose license to practice medicine has been suspended or revoked or who is under sentence of suspension or expulsion from a component society, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this association or of a component county society, nor shall he be permitted to take part in any of their proceedings until he has been relieved of such disability.

Sec. 4.—Each member in attendance at the Annual Convention shall register by indicating the component society of which he is a member. When his right to membership has been verified, by reference to the roster of his society, he shall receive a badge, which shall be evidence of his right

to all the privileges of membership at that convention. No member shall take part in any of the proceedings of an Annual Convention until he has complied with the provisions of this section.

CHAPTER II.—GENERAL MEETINGS

Section 1.—General Meetings shall mean all meetings planned for attendance by all registered members, and shall include those meetings in which guests of registered members or the general public are also invited. The address of the President may be delivered in a General Meeting, and the programs of General Meetings shall be arranged by the Executive Committee except where scientific papers are included, in which event the scientific part of the program shall be arranged by the Commission on Convention Arrangements, with the sanction and approval of the officers.

Sec. 2.—The General or Section Meetings may recommend to the House of Delegates the appointment of committees or commissions for scientific investigation of special interest and importance to the profession and public.

Sec. 3.—All scientific papers read before the Association or any of the sections shall become its property and shall not be published in any but the official publications of this Association, except by consent of the officers and the Editorial Board of this Association. Each such paper shall be deposited with the Executive Secretary when read.

Sec. 4.—The Council shall appropriate from the funds of the Association for such an amount as in the discretion of the Council shall be reasonably needed for that purpose, and no commitments shall be made for expenses in excess of the amount appropriated for such Convention. The funds so appropriated shall, upon the approval of the Executive Committee, be expended at the direction of the Commission on Convention Arrangements appointed by the President for the Convention for which the appropriation is made. All money in excess of that expended for actual expenses incurred shall revert each year to the treasury of the Association.

CHAPTER III.—SECTIONS

Section 1.—During the Annual Convention the Association in addition to the general meetings may hold the following section meetings:

a. Surgical.
b. Internal Medicine.
c. Eye, Ear, Nose, and Throat.
d. Anesthesia.
e. General Practice.
f. Obstetrics and Gynecology.
g. Preventive Medicine and Public Health.
h. Radiology.
i. Nervous and Mental Diseases.
j. Any other sections that hereafter may be provided for by the House of Delegates.

Sec. 2.—The officers of each section shall be a Chairman, a Vice-Chairman, and a Secretary, and they shall preside over the meetings of the sections and shall be responsible to the Committee on Scientific Work for the section speakers and papers.

Sec. 3.—The election of officers of the sections shall be the last order of business of the last meeting of the sections during the Annual Convention.

Sec. 4.—No section meeting shall be allowed to conflict with a general meeting.

CHAPTER IV.—HOUSE OF DELEGATES

Section 1.—The House of Delegates may meet on the day before the date set for the beginning of the general registration of the attendance at the Annual Convention. It may adjourn from time to time as may be necessary to complete its business, provided that its hours shall conflict as little as possible with the General or Section Meetings. It shall meet on the last day of the Annual Convention for the election of officers for the ensuing year, and for the completion of any business previously introduced. The order of business shall be arranged as a separate section of the program.

Sec. 2.—Each component county society shall be entitled to send to the House of Delegates each year one delegate for every fifty members and one for each major fraction thereof; but, irrespective of the number of members, each component society which has made its annual report and paid its assessments, as provided in this Constitution and Bylaws, shall be entitled to one delegate, except that where a component society is made up of physicians of more than one county, each county shall be entitled to at least one delegate and one alternate delegate who shall be a resident of the county he represents as a delegate or alternate delegate and who shall be selected by the physicians residing in such county.

The number of Delegates to which each Component Society is entitled shall be based upon the number of members on record in the office of the Executive Secretary in good standing with current dues fully paid as of December 31 of the preceding year.

The names of duly elected delegates and alternates from each component society shall be sent to the Executive Secretary of this Association on or before February first prior to the Annual Convention at which such delegates are to serve. No one shall be entitled to a seat in the House of Delegates unless his credentials as a delegate or alternate, properly signed by the secretary of his county society, be presented to the Committee on Credentials at the time of the Annual Convention.

Sec. 3.—Fifty delegates shall constitute a quorum.

Sec. 4.—The House of Delegates shall:

a. Elect representatives to the House of Delegates of the American Medical Association in

accordance with the Constitution and Bylaws of that body.

b. Divide the State into Councilor Districts, specifying what counties each district shall include, and when the best interests of the Association and profession will be promoted thereby, organize in each district a medical society, and all members of component county societies, and no others, shall be members of such district societies.

c. Have authority to appoint committees for special purposes from among members of the Association who need not be members of the House of Delegates. Such committees shall report to the House of Delegates, and the members of such committees may be present and participate in the debate on their reports.

d. Approve all memorials and resolutions issued in the name of the Association before the same shall become effective.

Sec. 5.—Proposals calling for appropriations of funds by the House of Delegates shall be submitted to the Council for its recommendation before final action of the House.

Sec. 6.—At the first meeting the President shall announce the membership of the reference committees, as hereinafter provided for, and any other committees considered by him necessary to expedite the business of the Association.

Sec. 7.—All resolutions to be presented to the House of Delegates for action shall be prepared and mailed to the Executive Secretary of the Association so that he will receive them not later than forty-five days prior to the meeting of the House of Delegates to which the resolutions will be presented for action.

Provided, that this sub-section of the Bylaws may be suspended with respect to any resolution upon a two-thirds majority vote of the House of Delegates.

Sec. 8.—The final vote on any issue calling for changes in dues or in dues structure or any changes in the Constitution and Bylaws shall be by roll call vote. Each member's vote shall be permanently recorded and no suspension of this rule will be allowed on the final vote of such an issue.

CHAPTER V.—ELECTION OF OFFICERS

Section 1.—The election of officers shall be the first order of business of the House of Delegates after the reading of the minutes on the last day of the Annual Convention.

Sec. 2.—All elections shall be by ballot, and a majority of the votes cast shall be necessary to elect. In case no nominee receives a majority on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken.

Sec. 3.—Any person known to have solicited votes for or sought any office within the gift of this Association shall be ineligible for any office for two years

Sec. 4.—The President, President-elect, and the Treasurer shall serve from the termination of the annual meeting of the House of Delegates in which the President-elect and Treasurer are elected until the termination of the succeeding annual meeting of the House of Delegates.

CHAPTER VI.—DUTIES OF OFFICERS

Section 1.—The president, or a member designated by him, shall preside at all general meetings of the Association and of the House of Delegates. The President shall appoint all committees not otherwise provided for; he shall deliver an annual address at such time as may be arranged by the Executive Committee, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the state during his term of office, and as far as practicable, shall visit by appointment the various sections of the state and assist the Councilors in building up the county societies and in making their work more practical and useful.

Sec. 2.—The President-elect's term of office shall be for one year, at the completion of which he succeeds to the presidency. While President-elect, he shall assist the President in the discharge of his duties.

Sec. 3.—The Treasurer shall give bond at the expense of the Association in such an amount as shall be required by the Council. He shall receive all bequests and donations to the Association and shall demand and receive all funds due the Association except accounts due THE JOURNAL in the conduct of its business. The funds of the Association shall be deposited in a depository or depositories designated by the Executive Committee, and withdrawals from such funds shall be made on checks or drafts signed by the Treasurer and the Chairman of the Council. He shall present to the House of Delegates annually a report of the receipts and expenditures, and the state of the funds in his hands, and shall subject his accounts to an annual audit by a Certified Public Accountant.

Sec. 4.—The Executive Secretary shall be the directing manager of the Association's headquarters and JOURNAL offices, and shall supervise the work of all salaried employees in the Association offices. Such supervision shall be subject to directives from the House of Delegates, the Council, the Executive Committee, and the President of the Association. He shall discharge the administrative functions of the Association not within the duties of other officers or of committees to perform. He shall assist, at their request, all officers and committees, and shall keep himself informed in regard to non-professional matters affecting the medical profession, for the purpose of

keeping himself qualified to perform the services herein mentioned. He shall be responsible for the execution and carrying out of the policies of the Association and in that connection shall perform all specific tasks committed to him by the committees, the Council, and the officers of this Association. The amount of his salary shall be fixed by the Executive Committee on approval of the Council.

Sec. 5.—The necessary expenses of the above officers incurred in the line of duty herein imposed shall be allowed for in the budget, but excepting the Executive Secretary, this shall not include the expenses of attending the Annual Convention.

CHAPTER VII.—COUNCIL

Section 1.—The Council shall meet as follows: 1. January, April, and July of each year on dates and at places fixed by the Council. 2. On the day preceding the first day for the scientific meetings of the Annual Convention of the Association. 3. On the last day of the Annual Convention of the Association after the adjournment of the House of Delegates. 4. At such other times as necessity may require, subject to the call of the Chairman, or on petition of three Councilors. It shall hold no meeting that will conflict with any meeting of the House of Delegates. It shall elect a Chairman, and a Clerk, who, in the absence of the Executive Secretary of the Association, shall keep a record of its proceedings. It shall, through its Chairman, make an annual report to the House of Delegates. It shall organize itself at the meeting following the final session of the House of Delegates by electing its chairman who shall serve for one year. The chairman of the Council shall be elected by secret ballot. The number of terms of the chairman shall be limited to not more than three in succession.

Terms of Councilors shall begin with the first meeting of the Council following the final session of the House of Delegates at the Annual Session.

Sec. 2.—Each Councilor shall be organizer, peacemaker, and censor for his district. He shall visit the counties in his district at least once a year for the purpose of organizing component societies where none exist; for inquiring into the condition of the profession, and for improving and increasing the zeal of the county societies and their members. He shall make an annual report of his work and of the condition of the profession of each county in his district, the same to be published in the number of THE JOURNAL which is issued immediately preceding the Annual Convention. The House of Delegates may take such action, if any, as it deems appropriate upon such reports. The necessary expenses incurred by such Councilor in the line of the duties herein imposed may be allowed by the Council on a properly itemized statement, but this shall not be construed to include his expense in attending the Annual Convention of the Association.

Sec. 3.—The Council shall, through its officers and otherwise, give diligent attention to and foster the scientific work and spirit of the Association, and shall study and strive constantly to make each Annual Convention a stepping stone to future ones of higher interest.

Sec. 4.—The Council shall, in connection with the House of Delegates, consider and advise as to the interests of the profession and of the public in those important matters wherein it is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation and to diffuse popular information in relation thereto.

Sec. 5.—The Council shall make careful inquiry into the condition of the profession of each county in the state and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist, and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse among physicians of the same locality and shall continue these efforts until every physician in every county of the state who can be made reputable has been brought under medical society influence.

Sec. 6.—The Council shall encourage postgraduate and research work, as well as home study, and shall endeavor to have the results utilized and intelligently discussed in the county societies.

Sec. 7.—The Council shall, upon application, provide and issue charters to county societies organized to conform to the spirit of this Constitution and Bylaws.

Sec. 8.—In sparsely settled sections it shall have authority to organize the physicians of two or more counties into societies to be designated by hyphenating the names of two or more counties so as to distinguish them from district and other classes of societies; and these societies, when organized and chartered, shall be entitled to all the privileges and representation provided herein for county societies, until such counties may be organized separately.

Sec. 9.—The Council shall be the Board of Censors of the Association. It shall consider all questions involving the rights and standings of members whether in relation to other members, to the component societies, or to this Association. All questions of an ethical nature brought before the House of Delegates or the General or Section Meetings shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members of component societies on which an appeal is taken from the decision of an individual Councilor, and its decision in all such matters shall be final.

Sec. 10.—The Council shall provide for and superintend all publications of the Association, and

shall have authority to appoint an editor and such assistants as it deems necessary, and fix the amounts of their salaries. The proceedings of the Council for the year shall be reported to the House of Delegates at the Annual Convention and be published in the number of THE JOURNAL which immediately precedes the Annual Convention.

Sec. 11.—In the interim between the meetings of this Association the Council shall be the executive body of the Association with full power to fill vacancies or transact any business that emergencies or the welfare of the Association may require.

Sec. 12.—The Council shall at its meeting following the close of the House of Delegates elect two members of the Association, at large, or of the Council, who, with the President, the President-elect, the Treasurer, and the Chairman of the Council, shall constitute and be known as the Executive Committee. If such members of the Executive Committee be not members of the Council they shall not have the power of vote in the Council.

CHAPTER VIII.—ORGANIZATION OF ACTIVITIES AND RESPONSIBILITIES

Section 1.—The work of the Association, the performance of which is not provided for elsewhere in the Constitution or Bylaws, and is not carried on in the meetings of the Council or of the House of Delegates, or by Special Committees created by the Executive Committee, the Council, or the House of Delegates, shall be performed by the following standing committees and commissions:

The Executive Committee
The Grievance Committee
The Student Loan Committee
The Medical-Legal Review Committee
The Commission on Convention Arrangements
The Commission on Constitution and Bylaws
The Commission on Legislation
The Commission on Public Information
The Commission on Governmental Medical Services
The Commission on Public Health
The Commission on Voluntary Health Agencies
The Commission on Medical Economics and Insurance
The Commission on Inter-Professional Relations
The Commission on Medical Education and Licensure
The Commission on Special Activities
The Commission on the Aged and Aging

The difference between committees and commissions is shown in the provision of these Bylaws pertaining to their work and composition.

Sec. 2.—Unless otherwise provided in these Bylaws, the committees shall be appointed by the President with the chairman of each committee designated by him, and the number constituting each committee shall be as indicated in the section of these Bylaws pertaining to each particular committee.

Sec. 3.—Each commission will consist of fifteen members appointed by the President, with at least one member from each councilor district. The original appointees in each commission shall be divided into three groups by lot. The first group shall serve three years; the second, two years; and the third, one year. Thereafter, each incoming President shall appoint five members of each commission to fill the vacancies resulting from the expiration of the terms of members, and such appointments shall be for three years. The President shall also appoint members to fill the unexpired term where any vacancy occurs through death, resignation or otherwise.

Sec. 4.—The President shall have the power, with the approval of the Council, to remove any member of any committee or commission where such member, for any reason, does not or cannot work at attempting to perform the duties pertaining to membership on such committee or commission.

Sec. 5.—Unless otherwise provided in these Bylaws, no member of either a committee or a commission shall serve on the same committee or commission more than two consecutive terms, but this shall not prevent him serving more than two terms if the term of another member intervenes. The time given to the serving of an unexpired term shall not be considered in determining the period within which a member may serve consecutively.

Sec. 6.—Within sixty days after the meeting of the State Convention, the President will call all commissions and committees into a joint meeting in which he will give a statement of the duties and responsibilities of all committees and commissions, call special attention to any immediate problems confronting the Association, and assign such problems or parts thereof to appropriate committees and commissions. Then this joint meeting will divide into meetings of the separate commissions, at which time the commissions and committees will organize by the election of chairman, vice-chairman and secretary, unless otherwise provided for in these Bylaws. In these meetings the commissions may provide for such subcommittees within the separate commissions as they may deem advisable. Each committee or commission shall have the right to call upon other committees, commissions or members of the profession for counsel and advice with respect to its work.

Sec. 7.—Each committee and commission shall have the privilege and is encouraged to have joint meetings with any like committee or commission of the Auxiliary where such like committee or commission exists, for the purpose of coordinating their activities to make them more effective in the medical service of the public and the intent of the Association.

Sec. 8.—Each committee and commission shall have the duty and responsibility of keeping constantly and currently informed on the matters

within the area of its special interest and activity; of studying the conditions within that area with the purpose of finding possibilities of improvement; of finding the best solutions it can to the specific problems referred to it; of contributing in its area to the achievements of the Association as a whole in the protection and improvement of the health of the whole human family; and finally of making all its efforts useful by passing on to the Association in the most effective manner possible the results of its studies and activities in its own area of special interests.

Sec. 9.—The President and Executive Secretary shall be *ex officio* members of all the foregoing committees and commissions without voting rights where their inclusion on the committee or commission is not otherwise provided for in these Bylaws.

CHAPTER IX.—THE EXECUTIVE COMMITTEE

Section 1.—The Executive Committee, constituted as provided in Section 12 of Chapter VII of these Bylaws, shall hold its first meeting immediately following the meeting of the Council held at the close of the last meeting of the House of Delegates in the Annual Convention, and shall organize by electing its chairman. Its secretary shall be the Executive Secretary of the Association. It shall meet with the Executive Secretary on the call of the Chairman, or of any three members, to plan and execute such work as may be necessary for the welfare of the Association and the conduct of the Executive Secretary's office. It shall have all jurisdiction with respect to medical defense activities of the Association and shall be governed by the rules it adopts concerning that activity and by the Bylaws of this Association. It shall make decisions for the Association, including matters pertaining to THE JOURNAL, during the intervals between the meetings of the Council, and shall report its actions to the Council.

Sec. 2.—It shall prepare a budget for the ensuing fiscal year; and all expenditures of the Association, except those otherwise provided for under the Constitution and Bylaws, shall be governed by the budget. No expense not provided for in the budget or otherwise under the Constitution and Bylaws shall be incurred by any officer, commission or committee. A committee, commission or officer may submit a request for funds to meet unusual expenses not included in the annual budget, and the Executive Committee shall have the power, by a two-thirds vote, to amend the budget to provide such funds.

CHAPTER X.—THE GRIEVANCE COMMITTEE

Section 1.—The Grievance Committee shall be composed of nine physicians, three of whom may be past presidents of the Association, and all of whom shall be appointed by the President. Not more than two physicians shall be appointed from any one councilor district. No member shall hold any elective office in the State Association during tenure on this committee. Of the nine physicians first appointed, three shall serve for a period of one year; three for two years; and three for three years. Thereafter, three shall be appointed each year for a three-year term to fill the vacancies caused by the expiration of terms. Any vacancy occurring in this committee, other than by expiration of term, shall be filled by an interim appointee to serve the balance of the unexpired term. This committee shall organize itself by electing a chairman, a vice-chairman and a secretary.

Sec. 2.—This provision regarding the constitution of the Grievance Committee shall be construed to mean that the present committee of that name is continued in that position with the terms of its members expiring and new members to be appointed on the basis of this provision being operative and effective as of the dates of their respective original appointments; and it is not to be construed as having the effect of creating a new committee, all of whose members are to be appointed upon this amendment being adopted and becoming effective.

Sec. 3.—In addition to the above provided organization and membership of the committee, the President of the Association shall appoint an accredited psychiatrist as a consultant for the committee, whose tenure of office shall be on an annual basis. The appointment of the psychiatrist may be made from any councilor district of the Association, irrespective of the membership of the committee including another member or members from the same councilor district. He shall have the same rights and privileges as other members of the committee except that he shall not have the right to vote.

Sec. 4.—The duties of this committee shall be to receive complaints, appeals or suggestions from physicians or laymen concerning professional conduct. It shall attempt to find the facts regarding any matter brought to its attention, through procedures proper and appropriate to that end, and shall attempt to adjust differences between patients and physicians, and between physicians. It may, if it believes the facts justify such action, cite a member of the Association to the Council of the State Association. It shall, subject to the approval of the Council, draw up a set of rules and regulations governing its procedure and official actions.

CHAPTER XI.—THE COMMISSION ON CONVENTION ARRANGEMENTS

Section 1.—The Commission on Convention Arrangements, with the advice and assistance of the Executive Secretary, shall provide suitable accommodations for meetings of the Association, including the House of Delegates, Council, and of their respective committees, the scientific and technical exhibits, and in conjunction with the Executive Secretary, shall have general charge of all the arrangements. Its chairman shall report an outline of the arrangements to the Executive Secretary

of the Association for publication in THE JOURNAL and in the official programs, and shall make additional announcements during the session as occasion may require. The arrangements and the character of any and all technical exhibits must meet with the approval of the Executive Committee of the Association.

Sec. 2.—It shall, with the approval of the Executive Committee, prepare a program for scientific work for the annual convention in which shall be included the respective programs for section meetings which shall be prepared through cooperation with the officers of the various sections; and it shall, with the approval of the Executive Committee, arrange for scientific exhibits as a part of the Annual Convention.

Sec. 3.—The general, scientific and sectional programs, and the financial arrangements to provide for them must be approved by the Executive Committee before being officially announced.

CHAPTER XII.—THE STUDENT LOAN COMMITTEE

Section 1.—The Student Loan Committee shall be constituted as follows:

(a) The President of Indiana State Medical Association
(b) One Councilor of the Association to be appointed by the President
(c) One general practitioner to be appointed by the President
(d) One specialist to be appointed by the President
(e) The Treasurer of Indiana State Medical Association
(f) The Dean of Indiana University School of Medicine
(g) One of the attorneys of Indiana State Medical Association to be appointed by the President

Sec. 2.—This committee shall have authority to make loans to medical students in accordance with the terms and conditions under which funds are made available for that purpose. The committee shall organize itself at its first meeting following the Annual Convention of the Association, by the election of a chairman and a secretary. The committee shall adopt its own rules and regulations, subject to the approval of the Council. The secretary shall have the duty and responsibility of keeping minutes of all transactions of the committee, and shall file a copy of such minutes, as well as a copy of all papers pertaining to any application or loans, in the Headquarters Office of the Association.

CHAPTER XIII.—THE MEDICAL-LEGAL REVIEW COMMITTEE

Section 1.—The Medical-Legal Review Committee shall consist of three members whose duty it shall be to meet in joint session and work with a similar committee to be appointed by the President of the State Bar Association. This committee of the Medical Association shall function as the medical representatives provided for in the Joint Inter-Professional Code of the State Medical Association and the State Bar Association to carry out the purposes of that Code. Its duties shall be as stated in that Code in the form in effect from time to time as approved by the Association.

CHAPTER XIV.—THE COMMISSION ON CONSTITUTION AND BYLAWS

Section 1.—The Commission on Constitution and Bylaws shall keep in contact with the developments and changes in procedures in carrying on the work of this Association; shall suggest revisions necessary to keep the Constitution and Bylaws always in accord with the practices and procedures best adapted to the functioning of the Association; and shall keep the practices and procedures of the Association consistent with the provisions from time to time contained in the Constitution and Bylaws—to the end that all members of the profession, by reference to the Constitution and Bylaws, may be able to obtain accurate information regarding procedure and practice within the Association, and that hampering of such procedure and practice by obsolete provisions in the Constitution and Bylaws may be avoided.

CHAPTER XV.—THE COMMISSION ON LEGISLATION

Section 1.—The Commission on Legislation shall study all legislation, both state and national, and all local legislative trends and movements, as to their effect upon the practice of medicine and the protection of the public health; shall keep the profession informed at all times concerning the matters within its area of responsibility; shall conduct investigations of legislative proposals; and shall maintain liaison with members of the State Legislature and of the United States Congress, and with the legislative activities of the American Medical Association. It shall strive to implement and make effective the legislative proposals adopted by the Association.

CHAPTER XVI.—THE COMMISSION ON PUBLIC INFORMATION

Section 1.—The Commission on Public Information shall collect and organize for dissemination to the public all matters of public interest within the field of medicine, including the activities of other commissions in which the public interest would be involved, and including also the achievements in the advancement of medicine which would be of interest to the public; shall disseminate all such information through the use of whatever media the Commission may find adaptable to that purpose so that such information may be brought to the public in the most effective and convincing manner; and shall develop and maintain the relations of the medical profession with the public in such a way as to give the lay public a better

knowledge and understanding of the aims, objects and value of the profession to the public.

CHAPTER XVII.—THE COMMISSION ON GOVERNMENTAL MEDICAL SERVICES

Section 1.—The Commission on Governmental Medical Services shall concern itself and assume special responsibility in obtaining information and giving counsel and advice to the Association with respect to all matters in which medical service comes into contact with any existing or proposed functions of government, including civil defense, rehabilitation of persons handicapped by abnormality or disease, medical service in welfare departments, maternal and child health programs sponsored through governmental agencies, medical care of military manpower, plans and programs for medical care of veterans, medical care for dependents of those in uniformed services of the Government, plans and programs of the Government for medical care now existing or which may hereafter be adopted by any special group, government programs for elimination of venereal disease and other communicable diseases, and all programs and plans for medical care to be provided through municipal, state or federal governments.

CHAPTER XVIII.—THE COMMISSION ON PUBLIC HEALTH

Section 1.—The Commission on Public Health shall assemble and study information regarding industrial medical practice, rural health, preventive medicine, placement of physicians, traffic safety, conservation of hearing and vision; and shall bring such information, and the possibility of progress and advancement in such fields, to the attention of the medical profession, with suggestions for improvements as the commission finds such possibilities.

CHAPTER XIX.—THE COMMISSION ON VOLUNTARY HEALTH AGENCIES

Section 1.—The Commission on Voluntary Health Agencies shall maintain liaison between all voluntary health agencies and the Association; shall study and counsel in regard to planning all educational and other activities of such agencies; and shall keep the Association fully informed at all times regarding present and contemplated programs of these agencies.

CHAPTER XX.—THE COMMISSION ON MEDICAL ECONOMICS AND INSURANCE

Section 1.—The Commission on Medical Economics and Insurance shall study and improve forms used in medical and hospital insurance; shall continuously be interested in all types of plans for prepayment of medical and hospital expense, and for provision for medical and hospital service through all types of group activity; shall maintain liaison with labor with respect to labor's problems involving medical and hospital care, and Workmen's Compensation problems; and shall seek improved solutions of professional liability or malpractice problems, tax problems in relation to medical practice, and problems involving physician retirement plans.

CHAPTER XXI.—THE COMMISSION ON INTER-PROFESSIONAL RELATIONS

Section 1.—The Commission on Inter-Professional Relations shall study to find all the best methods of maintaining on the highest and most satisfactory levels physicians' professional relations with hospitals, nurses, dentists, pharmacists, pharmaceutical manufacturers, veterinarians, nursing homes, and all other professional groups with which the practice of medicine comes into contact.

CHAPTER XXII.—THE COMMISSION ON MEDICAL EDUCATION AND LICENSURE

Section 1.—The Commission on Medical Education and Licensure shall maintain liaison with, and try to be of assistance to, medical schools and the licensing board; and shall keep in contact with, and endeavor to assist in improving, undergraduate education, postgraduate education, intern training, resident training, preceptor instruction, and public school health education.

CHAPTER XXIII.—THE COMMISSION ON SPECIAL ACTIVITIES

Section 1.—The Commission on Special Activities shall organize and promote support for the American Medical Education Fund, assistance to physicians, blood banks, and all miscellaneous activities not falling within the area of responsibilities of other commissions or committees.

CHAPTER XXIV.—THE COMMISSION ON THE AGED AND AGING

Section 1.—The duties of this Commission shall be to study, investigate, and make recommendations to the Association in the areas falling within the question of the aged and aging, including medical care programs, medical care insurance, rehabilitation, and preventive medicine.

CHAPTER XXV.—REFERENCE COMMITTEES

Section 1.—Immediately after the organization of the House of Delegates at each Annual Convention, the President shall announce the membership of the reference committees to serve during the convention for which they are appointed. Appointments to these reference committees shall be made by the President in time for them to be published in THE JOURNAL and the Handbook prior to such Annual Convention.

The President shall have the power to appoint substitutes from among the members present for absent appointees.

Each committee shall consist of five members, at least three of whom shall be members of the House of Delegates. The chairman shall be named by the President from among those who are members of the House of Delegates. To these committees shall be referred all reports, resolutions, measures

and propositions presented to the House of Delegates, except such matters as properly come before the Council, and the recommendations of these committees shall be submitted to the next meeting of the House of Delegates for acceptance in the original or modified form or for rejection.

Sec. 2.—The following Reference Committees are hereby constituted to which shall be referred all matters as indicated by the titles of the committees:

(1) Sections and Section Work
(2) Rules and Order of Business
(3) Medical Education and Hospitals
(4) Legislation
(5) Public Relations
(6) Hygiene and Public Health
(7) Amendments to the Constitution and Bylaws
(8) Reports of Officers
(9) Credentials
(10) Insurance
(11) Miscellaneous Business

Where a report, resolution, measure, or proposition deals with more than one subject matter, reference thereof may, in the discretion of the President, be made (a) to as many Reference Committees as are necessary to cover all subjects included therein; or (b) to only one Reference Committee which the President deems has within the scope of its reference the most important part of the matter referred.

No report of any Reference Committee shall be rejected on the ground that it covers something not included in the matters which such Committee was created to consider.

Sec. 3.—The time and place of meetings of all reference committees shall be publicly posted, and all meetings of all reference committees shall be open to all members of the Association.

Officers and chairmen of all committees whose reports are referred to reference committees shall have the right to appear and be heard before the respective committees to which such references are made, in regard to their reports.

CHAPTER XXVI.—COUNTY SOCIETIES

Section 1.—All county societies now in affiliation with this Association or those which may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and Bylaws, shall, on application receive a charter from and become a component part of this Association. The acceptance or retention of this charter shall be regarded as a pledge on the part of said component society to conduct itself in harmony with the letter and spirit of this Constitution and Bylaws and other rules and resolutions of this Association.

Sec. 2.—Charters shall be issued only upon approval of the Council and shall be signed by the President and Executive Secretary of this Association. The Council shall have authority to revoke the charter of any component society whose actions are in conflict with the letter and spirit of this Constitution and Bylaws.

Sec. 3.—Only one component medical society shall be chartered in any county. Where more than one county society exists, friendly overtures and concessions shall be made, with the aid of the Councilor for the district if necessary, and all of the members brought into one organization. In case of failure to unite, an appeal may be made to the Council, which shall decide what action shall be taken.

Sec. 4.—Each county society shall be judge of the qualifications of its own members, but, as such societies are the only portals to this Association and to the American Medical Association, every reputable and legally registered physician who holds a degree of Doctor of Medicine or a degree of Bachelor of Medicine, and who does not practice or claim to practice, nor lend his support to, any exclusive system of medicine, shall be eligible for membership. Before a charter is issued to any county society, full and ample notice and opportunity shall be given to every physician in the county to become a member.

Sec. 5.—Any physician who may feel aggrieved by the action of the society of his county in refusing him membership, or in suspending or expelling him, shall have the right to appeal to the Council, and its decision shall be final.

Sec. 6.—In hearing appeals the Council may admit oral or written evidence as in its judgment will best and most fairly present the facts, but in case of every appeal, both as a board and as individual Councilors in district and county work, efforts at conciliation and compromise shall precede all such hearings.

Sec. 7.—When a member in good standing in a component society moves to another county in this state, his name shall be transferred without cost to the roster of the county society into whose jurisdiction he moves, provided the transfer is approved by majority vote of the membership of said society to which the transfer is proposed.

Sec. 8.—A physician living on or near a county line may hold his membership in that county most convenient for him to attend, on permission of the society in whose jurisdiction he has his office or has the major part of his practice.

Sec. 9.—Each component society shall have general direction of the affairs of the profession in its county, and its influence shall be constantly exerted for bettering the scientific, moral and professional status of every physician in the county; and systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified and honorable physician in the county.

Sec. 10.—At the annual business meeting for election of other officers, in advance of the Annual Convention of this Association, each county society shall elect delegates and alternates to represent it in the House of Delegates of this Association, and the secretary of the society shall send a list of such delegates and alternates to the Executive Secretary of this Association annually on or before February first.

Sec. 11.—The secretary of each component society shall keep a roster of all its members and of the non-affiliated registered physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary. In keeping such roster the secretary shall note any changes in the personnel of the profession by death, or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

The secretary of each component society shall prepare and send to the Councilor of his district a quarterly report briefly stating the activities of his county society including meetings, programs, changes in officers and personnel of membership. A copy of this quarterly report to the Councilor shall also be sent to the Executive Secretary of the State Association. The State Association shall supply each county secretary a form for these reports.

Sec. 12.—The fiscal year of the Association shall be from October 1 to September 30 of the succeeding year. The dues shall be collected by the calendar year and payable in advance.

The secretary of each component society shall forward the dues for his society, together with the roster of officers and members and list of non-affiliated physicians of the county, to the Executive Secretary of this Association, on or before January 1 of each year and he shall promptly report thereafter the names of any new members elected to membership in his society, and promptly forward to the Executive Secretary of this Association the dues for such new members.

The dues shall be the same for all members and entitle the members to all benefits, including the publications of this Association, from the time of paying the dues to the close of the year only. Provided, however, that physicians elected to their first membership in this Association during the first nine months of any year shall pay the regular annual dues for that year; and those elected to their first membership after October 1 of any one year shall pay fifty percent of the annual dues as dues for the remainder of that year. Interns and residents shall pay $15.00 a year annual dues during their term of service in the hospital.

In the event the county society remits a member's dues on account of financial hardship, the secretary of the county medical society shall recommend in writing to the councilor of his district the remission of the state association dues of said member of the society, showing why such recommendation should be granted. The councilor in turn shall present the recommendation to the Council, which shall have the power to remit such dues.

Sec. 13.—Any county society which fails to pay its dues or make the report required by February 1 of each year shall be held suspended, and none of its members or delegates shall be permitted to receive any of the publications of the Association or participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met.

Sec. 14.—Each county society shall be held responsible for the faithfulness in the performance of duty on the part of its secretary in making reports and remitting dues to the Association.

Sec. 15.—Each component society shall have its own Constitution and Bylaws, which shall not be in conflict with the Constitution and Bylaws either of this Association or of the American Medical Association. An up-to-date copy thereof shall be filed with the Executive Secretary of the Indiana State Medical Association not later than May 1 of each calendar year, or where such copy is so on file and no change has been made, then it shall be sufficient to file a certificate to that effect with said Executive Secretary.

CHAPTER XXVII.—COUNCILOR DISTRICT MEDICAL SOCIETIES

Section 1.—A Councilor District Medical Society, hereinafter called the District Society, shall be a society whose members consist of the members of the County Medical Societies in the Counties which constitute the Councilor District, provided such members of County Medical Societies have paid their membership dues in the District Society.

Sec. 2.—The State shall be divided into thirteen (13) Councilor Districts with the boundary lines and numbers of each District to be as follows:

First District—Posey, Vanderburgh, Warrick, Spencer, Perry, Pike and Gibson Counties.

Second District—Knox, Daviess, Martin, Monroe, Owen, Greene and Sullivan Counties.

Third District—Dubois, Crawford, Harrison, Floyd, Clark, Scott, Washington, Orange and Lawrence Counties.

Fourth District—Jackson, Jennings, Jefferson, Switzerland, Ohio, Dearborn, Ripley, Decatur, Bartholomew and Brown Counties.

Fifth District—Clay, Vigo, Vermillion, Parke and Putnam Counties.

Sixth District—Shelby, Rush, Fayette, Franklin, Union, Wayne, Henry and Hancock Counties.

Seventh District—Morgan, Johnson, Marion and Hendricks Counties.

Eighth District—Madison, Delaware, Randolph, Jay and Blackford Counties.

Ninth District—Fountain, Montgomery, Boone, Hamilton, Tipton, Clinton, Tippecanoe, Warren, Benton and White Counties.

Tenth District—Newton, Jasper, Porter and Lake Counties.

Eleventh District—Carroll, Howard, Grant, Huntington, Wabash, Miami and Cass Counties.

Twelfth District—Wells, Adams, Whitley, Allen, Noble, DeKalb, LaGrange and Steuben Counties.

Thirteenth District—Pulaski, Fulton, Kosciusko, Marshall, Starke, LaPorte, St. Joseph and Elkhart Counties.

Sec. 3.—Each District Society shall adopt a Constitution and Bylaws, which shall not conflict with the Constitution and Bylaws of the State Association, and only one District Society shall exist within any one Councilor District. The authorized District Society in each Councilor District shall receive a charter from the State Association, and the Secretary of the District Society shall have custody of the charter.

Sec. 4.—Each District Society shall organize by electing a President, a Secretary, and a Treasurer and a Councilor and Alternate Councilor as the current Councilor term and Alternate Councilor term for the district expires, and such others as may be provided for in its Constitution and Bylaws. The office of Secretary and Treasurer may be held by the same physician. The Councilor shall continue to have the same duties and terms as are set forth in the Constitution and Bylaws of this Association.

Sec. 5.—The dues of the District Society, in an amount fixed by the District Society to meet the District Society needs, shall be collected by the Secretaries of the component County Societies and delivered to the Treasurer of the District Society. The Secretary of each District Society shall report to the office of the State Association the names and addresses of the members of his District Society, together with a copy of the minutes of each meeting of the District Society.

Sec. 6.—Each District Society shall meet at least once each year at a time and place to be fixed by the District Society. On or before January 1st of each year each District Society shall notify the headquarters of the State Association of the time and place of the annual District meeting for that year; but if no such notification has been received in the headquarters on or before the January meeting of the Council, the Councilor shall fix the time and place of the District meeting, and notice of such meeting shall be sent to the members of the County Medical Societies in such District.

Sec. 7.—Whenever a District Society is to elect a Councilor and/or Alternate, the headquarters office of the State Association shall so notify the individual members of such District Society not later than the first of March of the year in which the election is to occur.

Sec. 8.—The District Society shall send to the headquarters office of the State Association a copy of its program showing the time and place of its meetings, early enough that the headquarters office may notify all members within the District of the meeting at least thirty (30) days prior to the date thereof.

CHAPTER XXVIII.—MISCELLANEOUS

Section 1.—The deliberations of this Association shall be governed by parliamentary usage as contained in Robert's Rules of Order, when not in conflict with this Constitution and Bylaws.

Sec. 2.—The Principles of Medical Ethics of the American Medical Association shall govern the conduct of members in their relations to each other and to the public.

CHAPTER XXIX.—MEDICAL DEFENSE

Section 1.—One dollar and twenty-five cents out of the annual dues of each member of the Association shall be set aside as a special fund for medical defense.

Sec. 2.—The administration of medical defense of this Association shall be intrusted to the Executive Committee, which shall constitute the Medical Defense Committee of the Association.

Sec. 3.—This Committee shall have full authority governing all matters pertaining to this Chapter. In order to secure to any physician sued or against whom claim is made a fair and full presentation of his defense, the Committee shall have power to enter into an agreement with such physician to furnish to him funds with which to employ and pay one attorney of his choice and such other expenses as the Committee may approve as necessary to a fair and full presentation of his defense. Provided, always, that the attorney selected by the physician must be of good reputation and standing in his profession and the terms of employment, including the fees to be paid, must be approved by the Committee in each case in advance of such agreement. Provided, further, that the Executive Committee shall set a limit to the amount which may be so expended in connection with any one claim or case.

Sec. 4.—The Treasurer of the Indiana State Medical Association shall be custodian of the defense fund, separately kept, and shall give such additional bond as may be demanded by the Medical Defense Committee. Payments out of this fund shall be made only upon approval of the Executive Committee, by checks signed by the Treasurer and the Chairman of the Council.

Sec. 5.—The Medical Defense Committee shall make an annual report to the House of Delegates

of the cases in which it has been of service to members and furnish an account of the money received and expended, such report to be published in THE JOURNAL of the Indiana State Medical Association at the time and in the manner that reports of other committees of the Association are published.

Sec. 6.—This Association shall not be liable for any damage awarded, but shall be liable only for such expenses for the legal defense of its members as may be incurred in accordance with the terms of these Bylaws.

Sec. 7.—The Association shall not undertake the defense of a member in any case in which the member who applies for medical defense by the Association has failed to pay his annual dues for the year in which services were rendered which are the basis of the suit; and medical defense by the Association shall not be available in any suit based on services rendered during any period of delinquency in the payment of dues. Dues are payable on January 1, and become delinquent on February 1 of each year. The membership card of this Association, duly signed and dated by the Executive Secretary, shall be considered the only *bona fide* evidence of payment of dues or membership in this Association.

The Indiana State Medical Association shall in no case provide medical defense against any action for alleged malpractice against any physician unless such physician was a member of this Association in good standing at the time the services which are the basis of the suit were rendered.

Sec. 8.—A member desiring to avail himself of the services of the Medical Defense Committee in connection with litigation brought or threatened must send to the Executive Secretary of the Association for an application blank. After completing the data concerning the case he shall submit to a local committee of his county medical society—to be composed of the President, Secretary and one other member in good standing who may be nominated by the defendant—a full statement of the question at issue, including the diagnosis and treatment of the case and the names of physicians, nurses and other persons having knowledge of the same, who may be summoned as witnesses.

Sec. 9.—The committee of the county medical society shall immediately, after an investigation of all the circumstances and facts, transmit its report, with recommendations, to the Medical Defense Committee of this Association.

Sec. 10.—In the event that the county committee shall fail to recommend the case as one worthy of the recognition of this Association, a direct appeal may be made to the Medical Defense Committee of this Association, whose decision shall be final.

Sec. 11.—Suits brought against the estate of a deceased member shall be defended as if that member were alive; provided that such member was in good standing in the Association at the time of his death and that services for which indemnity is asked were rendered while the deceased was a member in good standing.

Sec. 12.—Medical defense shall not be available to members living outside of the State of Indiana at the time services were rendered for which indemnity is claimed.

Sec. 13.—The Medical Defense Committee shall have power to adopt such other rules, not in conflict with the foregoing, as in their judgment may seem necessary.

Sec. 14.—Medical defense as provided for by this Association shall be available to members under the terms stated in these Bylaws only in the defense of civil action for alleged malpractice, and shall not be available if such alleged malpractice occurred when the member was under the influence of any intoxicant or narcotic while rendering the service in question.

CHAPTER XXX.—DIVISION OF FEES

This Association does not countenance or tolerate fee-splitting, division of fees, or commission paying directly or indirectly, and any member found guilty shall be expelled from membership.

CHAPTER XXXI.—INVESTMENT OF SURPLUS FUNDS

Section 1.—The investment of all surplus funds of this Association shall be under the direct control and management of the Executive Committee subject to instructions in regard thereto which may be given by the Council at its option. The Executive Committee shall have the right and is encouraged to obtain the advice and counsel of the investment departments of any bank or trust company of Indianapolis in regard to the discharge of the duties covered by this chapter of the Bylaws.

CHAPTER XXXII.—AMENDMENTS

Section 1.—These Bylaws may be amended at any Annual Convention by a majority vote of all the delegates present at that convention, after the amendment has lain on the table for one day.

Sec. 2.—Upon the adoption of this Constitution and Bylaws all previous Constitutions and Bylaws are hereby repealed.

Principals of Medical Ethics of the American Medical Association

"PREAMBLE"

"These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

"Section 1.—The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

"Section 2.—Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

"Section 3.—A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

"Section 4.—The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

"Section 5.—A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

"Section 6.—A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

"Section 7.—In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

"Section 8.—A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

"Section 9.—A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

"Section 10.—The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community."

Your Blue Shield Board of Directors

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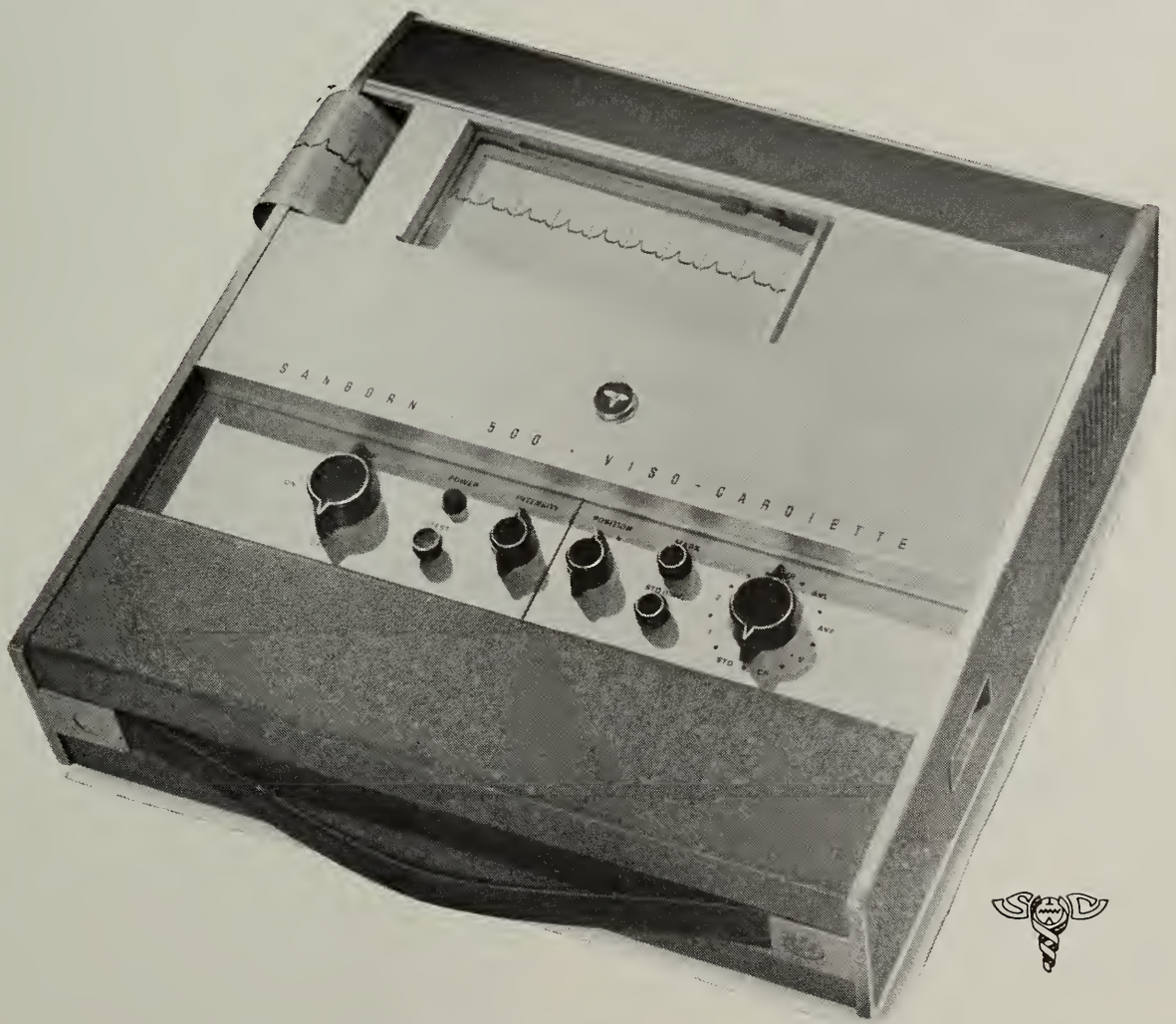
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JULY 1964

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Office of Publication

3935 N. Meridian, Indianapolis, Indiana

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EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members. Cost of color illustrations must be shared by the author.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible. However, the right is reserved to reduce in length or reject any article.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication in THE JOURNAL of the Indiana State Medical Association.

Communications dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 1802 North Illinois Street, Indianapolis 2, Indiana. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 3935 N. Meridian, Indianapolis 8.

Advertising rates will be furnished on request. Copy must be received by the 5th of the month preceding month of issue. (Scientific manuscripts must be received at least two weeks earlier if geared for a specific issue.)

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About Our Cover on page 732.

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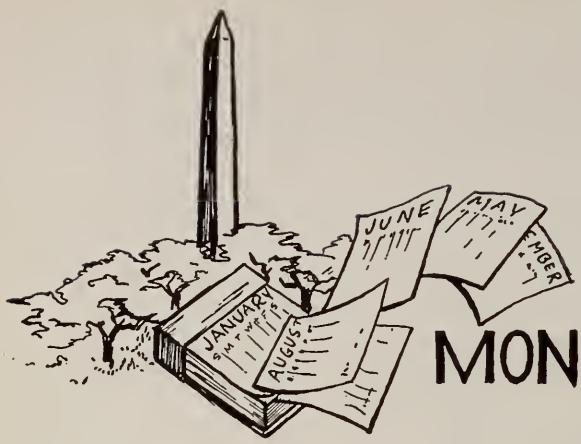


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This summary of what is happening in Washington is prepared by A.M.A.'s Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

MONTH IN WASHINGTON

WASHINGTON, D. C.—A new Food and Drug Administration regulation requires manufacturers to submit proof of effectiveness of drugs cleared between 1938 and June 20, 1963, and still on the market.

This retroactive regulation was the most controversial of a group of new drug regulations issued under the Kefauver-Harris FDA Act amendments enacted into law in 1962.

The Pharmaceutical Manufacturers Association said the government was "making a mistake in blanketing in drugs which have been regarded as old, safe and effective." The PMA questioned whether the FDA "has put too broad an interpretation on the 1962 drug amendments."

In protesting such a regulation before it was issued in final form, the PMA said a retroactive regulation would comprise "such sweeping requests for information as to be unreasonably burdensome on the industry . . . and ultimately on the Food and Drug Administration."

"The consumption of manpower, particularly of scarce, highly trained scientific personnel, that would be required to comply with the proposed regulations is staggering and bears no reasonable relationship to any possible benefit to the public," the PMA said.

"In fact the demand on the time of the scientific personnel of our member companies would be of such magnitude that it would impede and delay clinical research and the development of new drugs. Needless to say, such a result would not be in the public interest."

Drug manufacturers had argued that so-called "grandfather rights" allowed them to continue to make claims contained in new drug applications cleared in the past, and that they should not now have to produce medical evidence to support these claims.

The FDA disagreed. It held that Congress, in passing the drug amendments in 1962, specifically made it the agency's duty to review all medical claims for "new drugs" cleared in the past on safety alone, "with the intention that any claim unsupported by substantial medical evidence should be discontinued after next October."

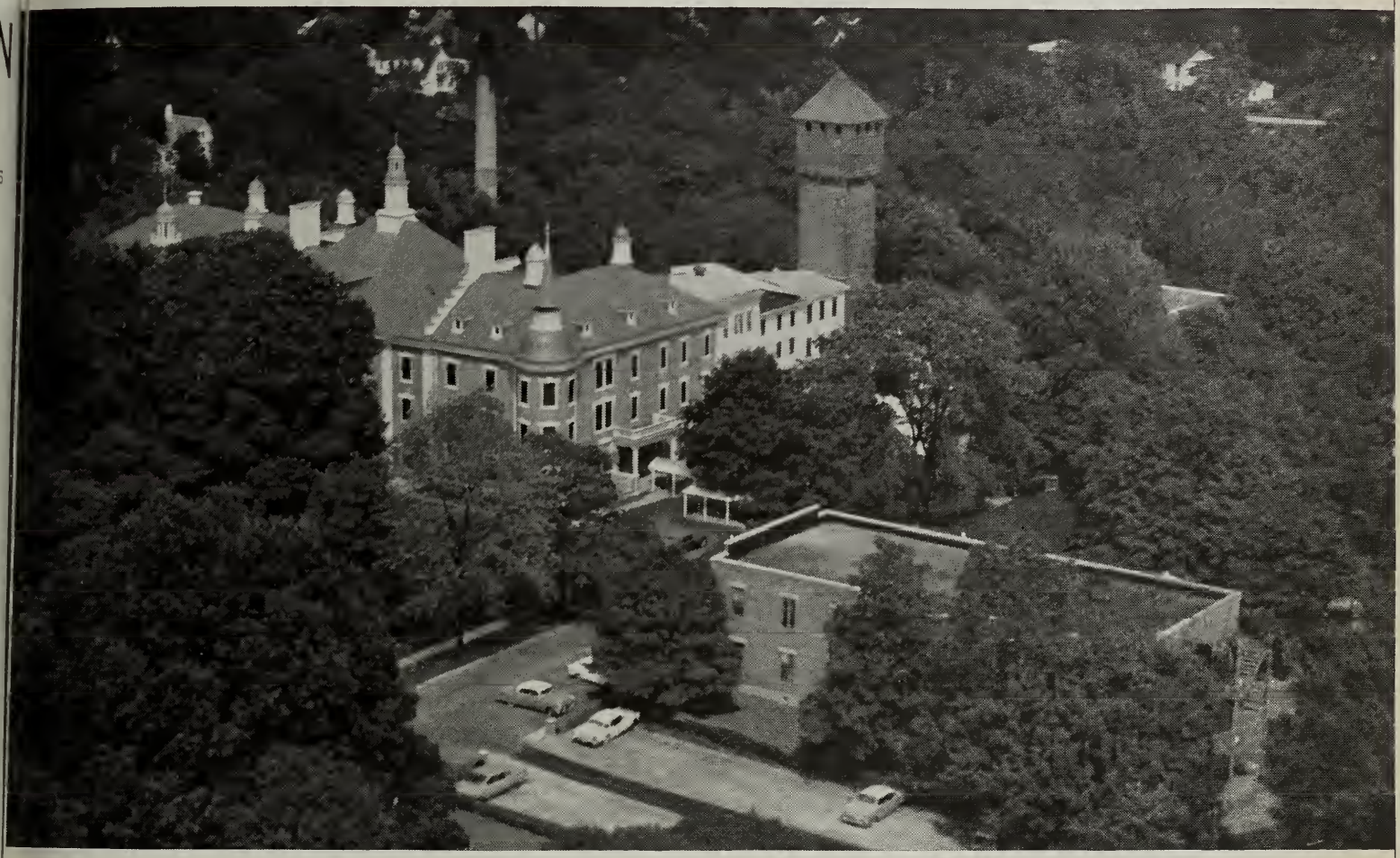
The FDA held that the "grandfather clause" gives the right to make unsupported claims for only two classes of drugs: (1) those on the market before 1938 and therefore exempted from new drug clearance by the 1938 Act, and (2) those introduced after 1938 which were generally recognized as safe and therefore were never cleared as "new drugs."

"We are glad that Congress has given us this unique opportunity to review past medical decisions permitting several thousand new drugs to go on the market. This review will include not only a new look at the safety of these

Continued

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Continued

drugs, but a first-time comparison of the actual promotional claims with the medical evidence on which they are based," FDA Commissioner George P. Larrick said.

The new regulations require firms marketing drugs approved since 1938 to examine both their promotional materials and their clinical records to be sure that all claims being made are justified by experience and that the promotional materials include all necessary warnings, contraindications, side effects and untoward reactions which may have shown up after the drugs were originally placed on the market.

Under the old law, new drugs were cleared on the basis of safety alone. There was no requirement that they be shown to be effective as well as safe for their intended uses, other than that claims of benefits be supported.

SPECIAL ASSISTANT TO HEW SECRETARY RESIGNS

Boisfeuillet Jones resigned as Special Assistant to the Secretary of Health, Education and Welfare effective June 30.

Jones told President Johnson in his letter of resignation that when he began the job as Special Assistant for Health and Medical Affairs in January, 1961, he expected to stay about two years, but challenges in the position kept him there longer.

"I shall return now to private life in Atlanta," Jones said, "in a unique situation which will permit me to engage in a side range of philanthropic activity, including health, education, and welfare with which my interests have long been identified."

Johnson replied that he acceded with reluctance to Jones' wish to return to private life.

Jones had been considered influential in HEW policy matters and often had been spokesman for the department and HEW Secretary Anthony J. Celebrezze. There were no advance indications that Jones would leave the department and his resignation came as a surprise.

BIRTH RATE IN NATION DECLINES

The Public Health Service has reported that the nation's birth rate has been declining steadily for the past two years. But the PHS anticipated a reversal of the downward trend.

There were 49,000 fewer births in the United States during the year ended March 31, 1964, than in the previous 12 months. The 337,000 births registered this March was the smallest number for the month since 1955.

An increase in marriages in March—to a total of 109,000—was interpreted as foreshadowing a reversal in the decline in the birth rate.

"The marriage trend," the PHS said, "is now showing signs of increase, but it would take some time for this to affect the birth rate. The age composition of the female population, with increasing numbers of women entering the childbearing ages, is also favorable to a higher level of fertility."

LESS CONSUMPTION=LESS WAISTLINE

The National Academy of Sciences has reduced its recommended daily calorie intake for adults on the ground that Americans are living a softer life with less physical activity.

The calorie requirement of the so-called "reference man"—25 years old,

Continued



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weight 145 pounds and moderately active—was cut to 2,900 calories daily from the 3,200-calorie diet recommended in 1958.

The recommended diet of the so-called "reference woman"—25 years old, weight 128 pounds and moderately active—was reduced to 2,100 calories per day from the 2,300 calories of 1952.

The recommended daily consumption of the nutrients thiamin, niacin and riboflavin were also cut.

The new revision included alcohol for the first time in the consideration of nutrients. The board estimated that Americans, on a per capita basis, consume 76 calories of alcohol per day. This estimate includes children and and other non-users and the average consumption of drinking adults is much higher.

The PHS also has reported that the decline in the U. S. death rate has been halted. This was attributed to (1) the leveling off of infectious disease deaths and (2) increased death rates from some chronic diseases and accidents.

Any further declines in the U. S. death rate probably will be small, the PHS said. ◄

About Our Cover

The hand — man's most valuable tool — an anatomic and engineering wonder. The normal hand is strong, skilled, eloquent and often beautiful. And the unique partnership between the hand and the brain differentiates man from all other animals.

The hands of a physician bring hope, solace and relief of pain.

It is hard to conceive of a hospital without a pair of "healing hands." And yet there will soon be mission hospitals in the Congo without anyone to treat the smallpox, tuberculosis, leprosy, malaria and other infectious diseases which the natives bring with them.

Indiana physicians who have given free medical service in the Congo have issued an appeal for other Indiana doctors to volunteer to serve. Under the sponsorship of the Indiana area of the Methodist Church, physicians serve three months without pay in an overseas area where emergency care is needed. Air transportation to and from the Congo is paid.

There are approximately 40 mission hospitals in the Congo, all in places where there have been missionairies for many years. Approximately 12 Indiana physicians have participated in the program, all serving in Congolese hospitals.

Now there are only two physicians definitely signed up to go.

Dr. Richard Nay was the first Indiana physician to participate in the "Operation Doctor" program begun by Methodist Bishop Richard C. Raines, of Indianapolis. Dr. Nay served three months in 1961 at a hospital in Kapanga and again in 1963 for three months.

"All of the men who have gone to the Congo have been most enthusiastic about their work," Dr. Nay said. "All have wanted to return at some future time. The people are so appreciative of whatever is done for them and most warmhearted in their treatment of the doctors. Any physician will be well repaid for the time it takes to go," Dr. Nay added.

Any physician interested in enrolling in the plan should contact Dr. Nay, 3524 N. Meridian Street, Indianapolis.—J.F.S.

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2. 'Deprol' relaxes physical tensions, restores normal sleep and revives interest in food.
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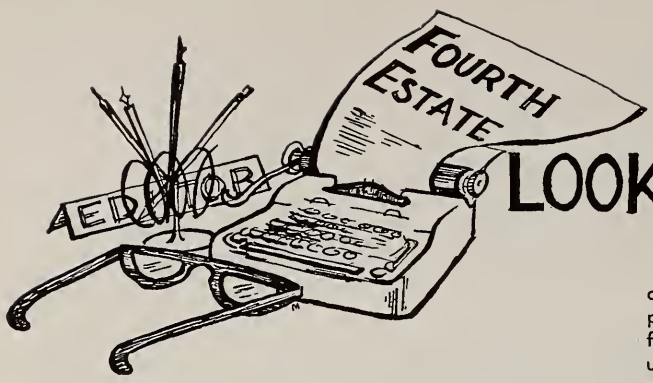
meprobamate 400 mg. + benactyzine hydrochloride 1 mg.

Side effects: Slight drowsiness and, rarely, allergic or idiosyncratic reactions, due to meprobamate, and occasional dizziness or feeling of depersonalization in higher dosage, due to benactyzine, may occur. **Contraindications:** Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use of meprobamate or meprobamate-containing drugs. **Precautions:** Should administration of meprobamate cause drowsiness, the dose should be reduced. Operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Although suicides with 'Deprol' have not been reported, prescribe cautiously and in small quantities to patients with suicidal tendencies. Massive overdosage of meprobamate may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Even though it has not been reported with 'Deprol', consider the possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage. *Complete product information available in the product package, and to physicians on request.*

Usual adult dosage: 1 tablet t.i.d. or q.i.d. May be increased gradually, as needed, to 6 tablets daily. With establishment of relief, may be gradually reduced to maintenance levels. **Supplied:** Light-pink, scored tablets Bottles of 50.

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CD-2022



LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Neither Advocates Nor Censors

The Marion County Medical Society seems to have made a sensible request in asking that public health nurses be allowed to discuss birth control.

The doctors may have stepped beyond the practical when they recommend that public health employees actively promote birth control practices.

At this time, nurses are not allowed to talk about birth control or family planning, even if a patient asks for such information. This strains good sense. Birth control is no longer reserved for the inner sanctum of the doctor's office, or the discreet confines of the druggist's counter. The public health nurse is barred from admitting what may be read in any number of magazines or newspapers.

Some authorities claim that mass production of soap and a ready supply of water have done more for public health than any other single advance. The public health nurse may recommend the beneficial effects of a bath without question. If a patient who is being aided by a nurse can receive information on cleanliness, factual discussion of such a basic matter as having children should not be banned.

Because each citizen is entitled to the free exercise of religious conviction, public officials should not, we think, positively urge birth control. While the Roman Catholic Church position is best known on this subject, beliefs of other religions also must be considered.

Yet, it is difficult to see how a small group of public employees can be put in the position of shutting their eyes to information that is available to those who consult a private physician, whatever their church affiliation. This is a sort of modern display of know-nothingism.

The rather emotional plea of one doctor about rejected children seems to be an exaggeration. A stronger case can be made for the straightforward presentation of factual information, without any advocacy on the part of public nurses.

It does not appear to be the job of the Marion County Health and Hospital Corporation to either oppose or support birth control. Nor should this public agency be required to censor the information available to its clients.

A sensible improvement in present rules would permit public health nurses to discuss birth control with the final decision still in the hands of the individual family.—*Indianapolis Star,* Feb. 18, 1964.

Alternatives to Compulsion

The number of older people covered by private health insurance programs continues its steady increase.

By the end of 1962—figures for 1963 are not yet available—the Health Insurance Institute reports that more than 10 million persons over 65 had some such coverage; that's 60% of all Americans that age or over. Indeed, the growth of private programs for people of all ages has been dramatic, from 42 million with some form of medical coverage in 1946 to more than 145 million today.

At the same time the number of people covered by the Kerr-Mills program keeps on rising. This is the federal-state plan to help those over 65 who need medical aid they can't afford. For those lacking both

health insurance and money, communities and private organizations are still providing their charitable services.

Naturally, we are not suggesting that all of this, impressive though it is, represents a complete answer to the problems of sickness among the elderly. We suppose there will always be people who through misfortune or improvidence reach old age in need, and they must be helped; there is no dispute about that.

What can be disputed is the contention of federal officials that no alternatives exist to the Administration proposal for Social Security financing of medical care for the elderly regardless of need. Alternatives to that costly piece of compulsion plainly do exist. And they are growing in health.—*Wall Street Journal*, Jan. 20, 1964.

Behind the Smoke Screen

Whatever anyone may think about the hazards of smoking, there are some basic issues in the government involvement in the controversy. It is one thing for federal authorities to sponsor a report on smoking, quite another for them to try to control the habit.

First we are presented with a ludicrous spectacle: the government which would use one of its arms—the Federal Trade Commission—to increase its regulation of manufacturers and advertisers is the same government which uses another arm—the Agriculture Department—to subsidize tobacco growers with price supports. An attempt to abolish the subsidy was recently defeated in Congress.

Though this leaves officialdom in flat contradiction with itself, it does indicate a more serious part of the problem. The tobacco industry, from grower right on through the whole chain to retailer and consumer, is a not insignificant element in the economy. If the government could put an effective crimp in it; it would be menacing a lot of businesses and a lot of jobs at a time when it is constantly complaining about the rate of unemployment.

It can be argued, to be sure, that the perils are great enough to justify the economic damage. But it is a remarkably discriminatory argument. Most experts concede that urban air pollution, for example, probably poses much the same perils, and efforts to control it have not been notably successful. Should the government therefore attempt to dismantle the industries that contribute to air pollution?

Then there is the question of the FTC's legal authority in the matter. The agency wants to require all cigarette advertising or labeling to warn that cigarette smoking may cause death, to avoid any implication that it promotes good health or physical well-being and to make no claim that any one brand is less harmful than another.

At hearings scheduled to begin this morning, however, a number of people will contend that such rules exceed the FTC's statutory power. And the proposed rules do seem to stretch the pertinent law, which bans unfair competitive practices. After all, to brand cigarettes as a cause of death is not exactly promoting fair competition; the intent and hope is to maim and if possible destroy an industry.

Here plainly is an issue which transcends that of smoking. The passion for control is a built-in vice of government regulators, and that is notably true of the FTC, with its innumerable pesky regulations and proceedings. Agencies should not be encouraged in their appetite for power, especially power of doubtful legality.

Not surprisingly, this attitude reveals a corollary trait of regulators: The tendency to regard the ordinary citizen as a boob.

In the present case, the dispute over smoking has been swirling through the nation for at least a decade, accompanied by untold millions of well publicized words setting forth the arguments pro and con. There is still some dispute about specific diseases to which smoking may be related, but no one at all is arguing that smoking is good for your physical health.

If people in general aren't aware of all this by now, then they must indeed be semimorons, just as some officious officials like to think. For our part, we don't take that arrogant view. People know very well what they are doing; some have chosen to give up cigarettes or not to start and others have chosen to risk whatever hazards there may be.

Continued

Common sense, it seems to us, suggests that the industry and its advertising men avoid any health claims or appeals to youngsters, and to a considerable extent they are avoiding such implications. Should they or any other industry make false claims or engage in unfair competition, the authorities can prosecute on that basis.

Beyond that, smoking should be left up to the individual. It is no area for federal intrusion behind the smoke screen of protecting us from ourselves.—*Wall Street Journal*, March 16, 1964.

Union Bosses Hit for Urging Medicare Bill

Dr. Edward R. Annis, president of the American Medical Association, today accused leaders of organized labor of "injustice to their members" in supporting the administration's medicare program.

Annis asserted that the increased Social Security taxes which would be imposed on the average American union member if the health insurance for the aged proposal is passed would "wipe out the savings they would get from the administration's proposal to reduce income taxes."

Annis asked union members to demand explanations of "why their leaders are so anxious to sell them out on this legislation."

"Union members should demand to know why their leaders are so eager to force higher taxes on them to pay hospital bills for half a million people over 65 who have incomes of $10,000 a year and more and 10 million others who already are protected with hospital insurance," Annis said.

"Why do labor leaders insist on a sock-the-worker payroll to finance medicare when they know that, by increasing the payroll tax, the $5,200-a-year union member would pay just as much as the $25,000-a-year union official?" Annis asked.

"Is this why the high-income union officials are so strong for medicare? Is it because they want to protect their income at the expense of their own union members and other lower-income wage earners?"

Annis made the statements at a District of Columbia Medical Society reception.—*Chicago Tribune*, Jan. 20, 1964.

To Do The Job Best

Star reporter Tom Karsell's examination into the problems confronting the State Department of Mental Health has drawn one nearly unanimous conclusion from everyone in authority who was quoted.

There are simply not enough psychiatrists and mental health workers to fill the vacancies in the state system.

Almost everyone also agrees that building larger and larger institutions is the wrong approach.

That leaves the small, previously not psychiatrically equipped, local community hospital as one means of filling the need of the state. And nursing homes as well as decently operated county homes can take up a great deal of the slack in geriatric cases. Most of the old people in the big institutions are merely senile and have no other need to be there.

Indiana has long prided itself on its determination to solve its own problems by independent action.

Here is a case where individual communities can take a big step forward toward erasing at least a part of the present dilemma of our crushing mental health case load.

Each town in this state ought to examine its own facilities for handling certain cases of the mentally ill. Admittedly, not all such cases can be handled on a local level but many can be.

Moreover, psychiatrists repeatedly have said that the general physician should not be afraid to tackle a psychiatric case of a milder nature. Certainly he has nothing to lose by trying before he simply consigns a patient to one of the big institutions, thereby increasing the state problem.

Here is a situation where each community can help the state—thereby helping keep state taxes down—by making an effort to absorb some of the mentally ill locally.

It's the best advice of the experts and worth a genuine try.—*Indianapolis Star*, April 24, 1964. ◄

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"Asymptomatic" Bacilluria in Diabetic Women

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CONTROL OF overt and occult infections of the renal parenchyma is of increasing importance in management of the diabetic patient. These infections lead to a gradual loss of functioning renal mass and may lead ultimately to death in renal failure. Hypertension may or may not accompany the renal complications of a chronic pyelonephritis, and accelerate the destructive process.

It has been well documented that urinary tract infections may exist with few or no symptoms and that examination of urinary sediment may not always indicate the presence of an active infection. Kass and other authors have shown that the quantitative culture technic of clear mid-stream urine specimens is a reliable indicator of significant bacilluria.[1-3]

Many investigators have reported an increased incidence in significant bacilluria in diabetic and hypertensive women, with or without clinical symptoms or abnormalities in the urine examination.[4-6] A study of 104 hypertensive women, followed regularly in the out-patient departments of the Marion County General Hospital, revealed an incidence of 23% with urine colony counts of 100,000 per milliliter or greater.[6]

This study was undertaken to determine the incidence of significant asymptomatic bacilluria in the female population of the Second Diabetic Clinic** at General Hospital. In addition, bacterial identification and antibiotic sensitivity patterns of these pathogens were determined.

Material and Methods

Sixty-five diabetic females were selected at random, from the Second Diabetic Clinic. None of these patients had unsolicited complaints of urinary tract difficulty, and each patient was questioned regarding the presence or absence of urinary tract symptoms. All of the patients were essentially asymptomatic except for a few nonspecific complaints such as nocturia or urinary frequency. Under the direct supervision of nurses experienced in obtaining specimens, mid-stream urine samples were obtained in the manner described by Martz and Griffith.[6]

Specimens were cultured within one hour on three differential media: blood agar, mannitol salt and MacConkey, using quantitative bacterial loops described by Hoeprich.[7] The plates were cultured at 37° and read at 24 hours. The organisms were identified by isolating them from the MacConkey media, and placing them on Kligler iron,

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urea agar and Simmons citrate. The proteus species were not studied for indole production. Proteus vulgaris and mirabilis were distinguished by their production of hydrogen sulfide. Separation of vulgaris strains and mirabilis strains was on the basis of citrate utilization.

If the colony count exceeded 100,000 per milliliter, antibiotic sensitivity was determined for the predominating organism or organisms using the disc-plate method on Mueller-Hinton media (Difco). Tes-Tape was used to detect glycosuria following culture of the specimen. Fasting blood sugar and blood urea nitrogen determinations were obtained on the same day that the urine was collected for culture.

The hospital records of each patient were reviewed for evidence of previous urinary tract infections and previous antimicrobial therapy, and to ascertain the degree of control, duration and severity of diabetes.

Results

The patients were classified into three groups on the basis of the initial cultures. Group I consisted of 31 patients with less than 10,000 organisms per milliliter. Group II was composed of 17 patients with colony counts between 10,000 and 100,000 organisms per milliliter. The remaining 17 patients with colony counts greater than 100,000 organisms per milliliter made up Group III.

There was no apparent difference between the groups in regard to duration, severity or control of diabetes. The average fasting blood sugar and blood urea nitrogen determinations were similar in each group. No significant differences in average blood pressure were noted in any of the groups, and there appeared to be no correlation between the presence or absence of glycosuria and high colony counts in the urine. This data is summarized in Table 1.

The patients in Group I were, on the average, younger than those in the other two groups. Ten patients in Group III, four in Group II, and 10 in Group I had a past history of urinary tract infections. A second culture was obtained from each patient in Groups II and III, except for one patient in Group II and one patient in Group III both of whom died prior to the second culture.

The results of the cultures from Group II are tabulated in Table 2. In only one case in this group did the number of organisms in the urine prove to be of clinical significance on the second culture. In the remainder of patients, the colony count remained in Group II (between 10,000 and 100,000 per milliliter) or reverted to Group I (less than 10,000 per milliliter) on the second culture.

GENERAL INFORMATION COMPARING THE THREE GROUPS

Group	Colony Count per ml.	No. of Patients	Average Age	Average Fasting Blood Sugar	Average Duration of Diabetes	Control of Diabetes*	Severity of Diabetes*	Average Blood Pressure	Past History of Urinary Tract Infection	Average Blood Urea Nitrogen	Urine Glucose at Time of First Culture	
											Neg. 1+	− 4+
I	> 10,000	31	50	167.5	8.3 yr.	2.2	1.5	148/89	10	17.6	18	13
II	10,000 to 100,000	17	57.1	190	10.3 yr.	2.4	1.6	167/91	4	18.0	**	9
III	> 100,000	17	60.8	199.8	8.5 yr.	2.5	1.8	166/87	10	19.5	8***	7

* Diabetes Index Scores:

Severity — Mild..... 1; Moderate..... 2; Severe..... 3

Control — Excellent..... 1; Good..... 2; Fair..... 3; Poor..... 4

** Test for glucose not available for one specimen.
*** Test for glucose not available for two specimens.

TABLE 1

RESULTS OF FIRST AND SECOND CULTURES OF INITIAL GROUP II
(Colony count between 10,000 and 100,000/ml.)

Patient	Previous Urinary Tract Infections	Previous Sulfa Therapy	Antibiotic Therapy for Previous GU Infections	Organism First Culture	Organism Second Culture	Colony Count/ml. Second Culture
N.B.	no	—	—	S. albus	S. albus	< 10,000 I
V.B.	yes	—	—	S. albus	S. albus	II
M.B.	no	—	—	S. albus	S. albus	I
L.B.	yes	Sulfasuxazole	—	S. albus	S. albus	I
C.B.	no	—	—	S. albus	no growth	I
I.C.	no	—	—	Pr. vulgaris	Pr. mirabilis	III
M.F.	no	—	—	S. albus	S. albus	I
M.G.	no	—	—	S. albus	S. albus	II
L.H.	no	—	—	S. albus	S. albus	I
L.Hu.	no	—	—	S. albus	S. albus	I
B.J.	no	—	—	Enterococcus	S. albus	II
N.J.*	no	—	—	S. albus	—	—
E.L.	yes	Sulfasuxazole	Tetracycline	S. albus	S. albus	II
A.M.	yes	Sulfasuxazole	—	S. aureus	S. aureus	II
E.R.	no	—	—	S. albus	S. albus	II
F.W.	no	—	—	S. albus	S. albus	I
V.W.	no	—	—	S. albus	S. albus	I

* Patient died prior to second culture.

TABLE 2

The results of the first and second cultures in Group III are shown in Table 3. Three patients in this group had Staphylococcus albus which, for purposes of this study, was considered to represent contamination. Of the 14 patients from whom urinary pathogens were recovered on the first culture, 10 were found to have significant

RESULTS OF FIRST AND SECOND CULTURES OF INITIAL GROUP III
(Colony Count > 100,000/ml.)

Patient	Previous Urinary Tract Infections	Previous Sulfa Therapy for GU Infections	Antibiotic Therapy for Previous GU Infections	Organism First Culture	Organism Second Culture	Colony Count/ml. Second Culture
V.A.	yes	Sulfasuxazole	—	S. albus	S. albus	II 15,000
L.B.	no	—	—	E. coli	E. coli	III > 100,000
M.B.	yes	Sulfasuxazole	Ilosone-Triple Sulfas	Pr. morgani	Alc. fecalis	III > 100,000
G.B.	yes	Sulfasuxazole	—	Pr. vulgaris	E. coli	I < 10,000
L.D.*	yes	Triple sulfas Sulfasuxazole	—	S. albus	S. albus	II 14,000
C.E.	yes	Sulfasuxazole	Nitrofurantoin	Pr. morgani	Pr. rettgeri	III > 100,000
K.F.	yes	Sulfasuxazole	—	Pr. vulgaris	Pr. vulgaris	III > 100,000
H.H.	no	—	—	E. coli	Paracolon	III > 100,000
B.H.	no	—	—	Pr. morgani	Aer. aerogenes	III > 100,000
F.K.	no	—	—	Pr. morgani	E. coli	III > 100,000
J.L.*	no	—	—	Paracolon	S. albus	I < 10,000
L.M.	yes	Sulfasuxazole Triple sulfas	—	Pr. morgani	S. albus	I < 10,000
E.M.	yes	Sulfasuxazole	Streptomycin	E. coli	Alc. fecalis †	III > 100,000
R.M.*	no	—	—	Pr. morgani	S. albus	I < 10,000
A.R.	no	—	—	Alc. fecalis	Alc. fecalis	III > 100,000
B.W.**	yes	Sulfasuxazole	—	S. albus	—	—
M.T.	yes	—	—	Paracolon	E. coli	III > 100,000

* Antimicrobial therapy between first and second culture.
** Patient died prior to second culture.
† Also klebsiella — 18,000 colonies.

TABLE 3

ANTIBIOTIC SENSITIVITY PATTERNS OF 26 URINARY TRACT PATHOGENS

	Chloramphenicol	Nitrofurantoin	Kanamycin	Neomycin	Polymyxin	Colistin	Tetracycline	Streptomycin	Sulfasuxazole	Triple Sulfas	Penicillin	Novobiocin
Proteus SP	*8/9**	9/9	8/9	7/7	5/9	5/9	3/9	3/9	0/9	0/9	2/9	2/9
E. coli	6/6	6/6	6/6	4/6	5/6	4/6	6/6	4/6	2/6	2/5	1/6	0/6
Paracolon	3/3	3/3	3/3	3/3	3/3	3/3	3/3	3/3	1/3	1/3	2/3	0/3
Klebsiella-Aerobacter	1/2	1/2	2/2	2/2	2/2	2/2	1/2	0/2	0/2	0/1	1/2	0/2
Alcaligenes fecalis	4/4	4/4	4/4	4/4	4/4	4/4	4/4	3/4	0/4	0/4	1/4	0/4
Total Strains	24	24	24	22	24	24	24	24	24	21	24	24
Total Sensitive	22	23	23	20	19	19	17	13	3	3	7	2
% Sensitive	91.6	95.8	95.8	90.9	79.1	75.0	70.8	54.1	12.5	14.2	29.1	8.3

* Number of strains tested
** Number of strains sensitive

TABLE 4

colony counts of urinary pathogens on the second culture. Insignificant colony counts were found in the other four patients. Of the latter, two patients had received antimicrobial therapy prior to the second culture—one for a non-genitourinary infection and the second on the basis of the first culture report.

A total of 26 pathogens were recovered and sensitivity studies were obtained in 24 of these. Eleven of the 26 pathogens were of the proteus group, thus proteus organisms represent 42% of the total.

The results of the sensitivity studies are listed in Table 4. A high incidence of sensitivity to chloramphenicol, nitrofurantoin, kanamycin and neomycin was evident in this group of organisms. They were moderately sensitive to polymyxin B, colistin and tetracycline. The organisms were relatively insensitive to sulfasuxazole, triple sulfas, penicillin and novobiocin.

Discussion

Of the 65 "asymptomatic" diabetic females from whom bacterial cultures of urine were obtained, 14 (22%) were found to have significant bacteriuria of pathogenic organisms on first culture. This correlates with a report by Kass who found 18% of 54 diabetic females to have significant bacteriuria.[3]

The results of the second culture correlated closely with the first culture in this series of patients. The finding of >100,000 organisms per ml. separates true bacilluria from contamination according to Kass.[8] If the colony count is 100,000 organisms per ml., this has a confidence level of 95% on a catheterized specimen, and 80% on a clean voided mid-stream specimen. If two such voided specimens have colony counts in the same range, the confidence level is then 95%.

MacDonald et al. have demonstrated from autopsy data the validity of colony counts in the diagnosis of urinary tract infections.[2]

In our series, proteus accounted for 11 of 26 pathogens while Escherichia coli was found in only six cultures. This is in con-

trast to a study by Barnard, Story and Root in which Escherichia was the organism most frequently found in a group of diabetic women.[9] Proteus accounted for only a small percent of the cultures in that study. It should be noted, however, that in their study the patients had urine cultures because of symptoms (31) or pyuria (21). All of our patients were asymptomatic at the time each specimen was obtained for culture.

Grossberg et al. noted a high incidence of proteus bacteriuria in diabetic subjects.[10] They reported a total of 31 strains of bacteria obtained from 20 diabetic subjects. Escherichia coli accounted for 15 of the bacterial strains and proteus for 11.

Yow reported cases of pseudomonas or proteus infection developing during or following antibiotic therapy.[11] This was presumably due to the elimination of sensitive bacteria and the multiplication of resistant bacteria. In our own series, six of the 15 patients who had significant bacteriuria had been treated with antimicrobials in the past for urinary tract infections.

Sensitivity studies revealed that, in general, this group of organisms was relatively insensitive to the commonly used sulfasuxazole and triple sulfas. A high degree of sensitivity was seen with chloramphenicol and nitrofurantoin.

Summary

1. Twenty-two percent of 65 diabetic females without urinary tract symptoms were found to have significant bacteriuria (>100,000 organisms per ml.).

2. A surprisingly high incidence of proteus bacteriuria was found in this group. Proteus accounted for 11 of 26 pathogens found, thus representing 42% of the total cultures.

3. No correlation was found between the incidence of hypertension, degree of diabetic control, presence or absence of glycosuria and urine colony counts of 100,000 organisms per ml. or greater.

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A Transverse Abdominal Incision for Pyloromyotomy

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HYPERTROPHIC PYLORIC STENOSIS is generally considered to be the most common disease requiring surgical correction in infancy. Although the management of these patients is almost standardized, a difference of opinion exists concerning the best operative procedure. Since 1956, we have used a transverse incision which has proved superior to those previously used. The technic and results will be described.

Technic

The skin and subcutaneous tissues are incised for three to four centimeters, beginning near the midline, approximately midway between the xiphoid process and the umbilicus, and extending laterally to the right (Figure 1). The anterior rectus sheath is also divided transversely. The rectus abdominis muscle is freed by blunt dissection. The lateral half of the rectus muscle is transected and the medial portion retracted towards the midline. The posterior sheath is incised transversely in one layer with the peritoneum.

The liver usually extends slightly below the incision and must be retracted upwards. In most instances, the distal stomach and pylorus are directly beneath the incision. The pyloric tumor is drawn into the wound and pyloromyotomy is carried out. The posterior and anterior sheath layers are closed with interrupted sutures of 0000 silk or dacron. The skin, which often is approximated by closure of the deeper layers, is sutured with a few interrupted stitches of 00000 chromic catgut or dacron.

Results

This incision has been used in 67 patients. All patients recovered and their wounds healed well. There was no instance of wound dehiscence or hernia. Most of the skin scars were narrow and not prominent (Figure 2).

Discussion

A number of abdominal wall incisions have been used for pyloromyotomy. A right upper rectus approach provides good exposure but has been associated with a relatively higher incidence of dehiscence. In addition, like other abdominal vertical incisions, it tends to be followed by a larger scar than those which are transverse.

Robertson[1] introduced a muscle-splitting incision in 1940 because of the occasional wound dehiscence or hernia which followed the rectus incision. This technic avoids the problem of wound disruption. However, those who recommend it admit that delivery of the pylorus may, in some cases, be troublesome, especially if the tumor is large.[2] In addition, the incision is more difficult to execute and extend.

A number of surgeons have pointed out the advantages of a transverse incision. Brunkow[3] advocated a high right transverse incision in 1936. All of the tissues were divided transversely except for the rectus muscle, which was retracted laterally. He originally used a right rectus approach but found that the small intestine usually lay immediately beneath and often was forced through the wound when abdominal pressure increased with straining. The higher transverse incision was free from this difficulty. Twenty-five patients were operated upon in his report. No wound complication occurred.

Davis[4] proposed a transverse incision in 1944 to obviate the difficulties of both the rectus and muscle-splitting incisions. He recommended transverse division of the layers anterior to the rectus muscle, fol-

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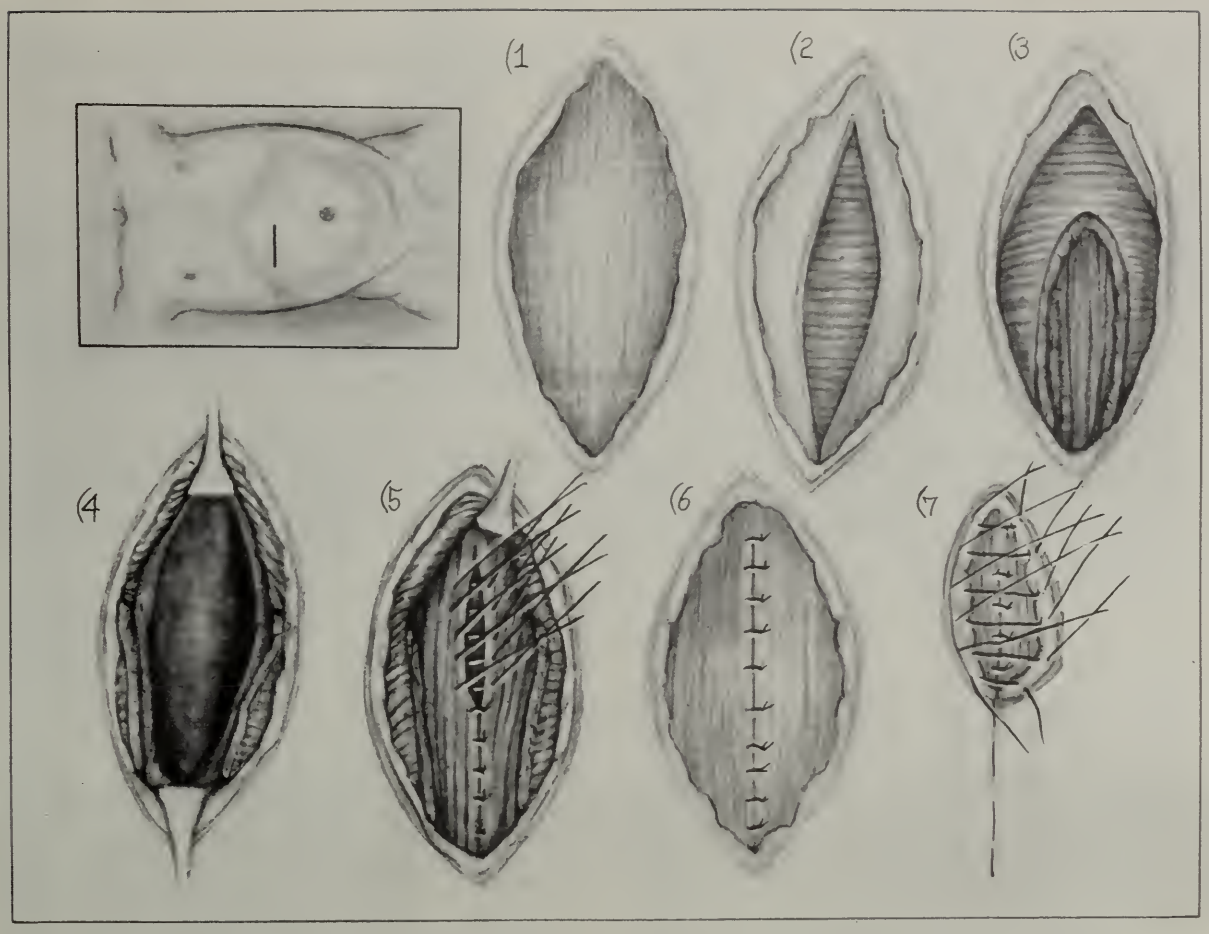


FIGURE 1

VARIOUS PHASES of making and closing the transverse incision for pyloromyotomy are shown. In (1, the skin and subcutaneous layer have been incised; in (2, the anterior rectus sheath; in (3, the lateral half of the rectus muscle; and in (4, the posterior sheath and peritoneum. Note how the liver extends below the wound. It is retracted upwards before the pyloric tumor is delivered.

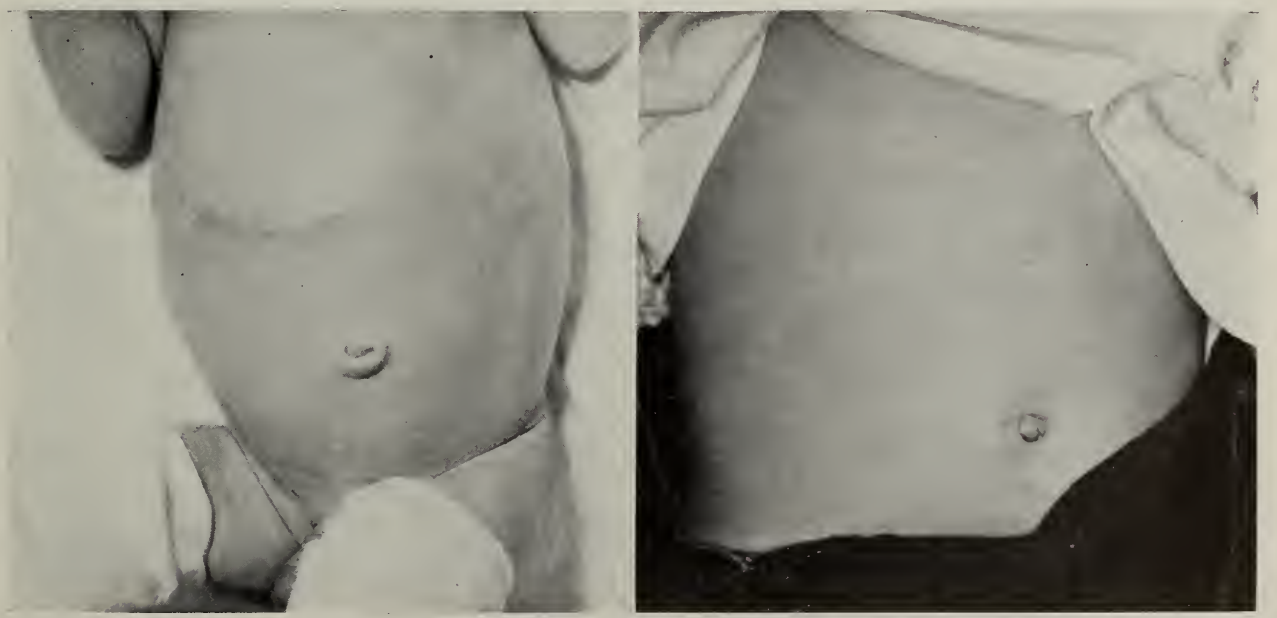


FIGURE 2

TWO PHOTOGRAPHS showing the abdominal wall three weeks after operation (left) and five months after operation (right).

lowed by vertical splitting of that muscle. The medial and lateral portions of the rectus were retracted and the posterior rectus sheath was incised transversely.

Horgan[5] proposed transverse division of the tissues down to the right rectus muscle in 1945. The entire muscle was then retracted medially and the posterior rectus sheath incised transversely. Thirty-four cases were operated upon with good results.

In 1949, Keeley recommended a transverse incision approximately four centimeters long which divided all layers including the right rectus muscle.[6] It was located anywhere from just below the right costal margin down to the level of the umbilicus, depending upon the point at which the pyloric tumor was palpated. It was used in 34 patients with no instance of wound disruption.

The incision described has certain advantages. It is easily made, and if necessary, conveniently extended. The nerves innervating the rectus muscle are not sacrificed or injured by vigorous retraction. The wound is located directly over the antrum of the stomach and pylorus, and the tumor is easily delivered. The tendency for small intestine to enter the operative area is minimized. Since fascial fibers in the rectus sheath are for the most part transverse, the immediate strength of the sutured wound is excellent. A minimal skin scar results.

Summary

The advantages of a transverse incision for the operation of pyloromyotomy are reaffirmed. An operative approach is described which is easily made, provides good exposure and heals well. The skin scar is good. Since 1956, it has been successfully used in 67 patients.

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The Complexities of Generic Equivalents

In many instances the most frequent error made is the assumption that if one places a specific quantity of a given drug in a dosage form, the product will provide the full biologic and therapeutic effects of the drug irrespective of how it is prepared, by whom it is manufactured, by whom it is taken, and when it is taken.

The literature indicates specifically that the mere presence of the labeled amount of drug in a given dosage form is no assurance of the therapeutic efficacy of the product. Here the physician must be concerned with the all-important question, "Will all similar products produce the same therapeutic response?"—Jaime N. Delgado, Ph.D. and Frank P. Cosgrove, Ph.D., in *Texas State Journal of Medicine,* October, 1963.

Congenital Leukemia*

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THE ETIOLOGIC PARAMETERS of any disease would seem to be naturally reduced to a minimum when the disease is observed in an infant immediately upon emerging from the protecting milieu of the uterus. This case of congenital leukemia is reported because leukemia in the newborn occurs rarely. The observations are of especial interest because the infant had an apparently complete hematological remission lasting for approximately nine-and-one-half months without anti-leukemic therapy. To our knowledge no other infant born with leukemic infiltrates of the skin has survived to the age of 11 months and two days.

Case Report of Mother

Logic strongly suggests that the prenatal maternal history might provide clues to the etiology of this unusual form of leukemia, and therefore the clinical history of the mother is given in some detail.

Forty-four days prior to the probable date of conception, the 26-year-old mother, para II, was seen by her physician. She had a lesion on the right leg over the tibia that clinically appeared to be ringworm. This was treated unsuccessfully with liquid 2 dimethylamino-6- (beta-diethylaminoethoxy) benzothiazole dihydrochloride (Asterol, Roche). Three days later the patient was febrile with muscle aches and pains and a slight pharyngitis. She was treated with oxytetracycline (Terramycin, Pfizer) 100 mgm. intramuscularly and 250 mgm. orally, four times a day for three days and was also given a-d-4-dimethylamino - 1, 2, diphenyl-3 methyl -2 propionoxybutane hydrochloride (Darvon, Lilly), one or two tablets four times a day as necessary. Eleven days later, the patient's ringworm was treated topically with a compound of unsaturated fatty acids (25% glyceryltriacetate, in an emollient base (Enzactin, Ayerst), an anti-fungal medication.

The patient's last normal menstrual period was approximately four weeks later. When the patient was believed to be two months pregnant she had acute rhinitis with a low fever and chills and was treated with oxytetracycline (Terramycin, Pfizer) 100 mgm. intramuscularly and 250 mgm. capsules four times a day for three days.

Three months after the last normal menstrual period, the pregnancy was confirmed and a history and physical examination carried out. The patient was found to be allergic to sulfa drugs and had frequent episodes of allergic rhinitis. The menstrual history included menarche at age 12 with a 32 to 33 day cycle and 7 day flow. Three years prior to this pregnancy she had delivered a 7 lb., 8 oz. full-term girl after a normal pregnancy. One year prior to the present pregnancy, the patient had delivered a 7 lb., 5 oz. full-term boy. There had been no history of blood transfusion. A family history disclosed good health in all close relatives, including the two children. A maternal uncle had arrested tuberculosis and there was a history of twinning on the paternal side of the family.

Physical examination revealed a weight of 109 lbs. (105 lbs. normal weight), and a blood pressure of 122 systolic, 60 diastolic. There were old, well-healed incisional scars on one breast from drainage of a breast abscess. The remainder of the physical examination was normal except for an en-

* This paper was presented to the Northern New England Academy of Medicine, January 23, 1963, at Jefferson Highlands, New Hampshire.

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FIGURE 1

THE INFANT APPROXIMATELY 18 hours after birth, (left) showing distribution of the skin nodules. The color of the nodules was more vivid at the time of birth. The skin nodules (right) were slightly raised and felt firm and indurated.

larged uterus of a size appropriate for three months gestation. The hemoglobin was 13 gms. per 100 ml., and the patient was found to be blood group A, Rh positive. She was then given "prenatal" vitamin capsules (brand unknown) and meclizine hydrochloride (Bonine, Pfizer), one tablet every 24 hours as necessary for nausea and vomiting.

In the fifth month of gestation she was given the fourth Salk poliomyelitis immunization (1 cc. intramuscularly). At this time the patient had otitis media and was treated with potassium alphaphenoxyethyl penicillin (Syncillin, Bristol), one tablet four times a day, and phenylephrine hydrochloride with chlorprophenpyramidine maleate, acetylsalicylic acid, acetophenetidin, and caffeine (Novahistine with APC, Pitman-Moore), two capsules every four hours.

In the sixth month of pregnancy the patient lacerated a finger and was given horse serum containing formaldehyde-detoxified tetanus toxin, preserved with a organomercurial, thiomersal 1:10,000 (Tetanus Toxoid, Lilly), 0.5 cc. subcutaneously.

In the eighth month of pregnancy the mother had an upper respiratory infection treated with 600,000 units of penicillin intramuscularly, and penicillin G tablets 250,000 units four times a day and pyrilamine tannate, chlorpheniramine tannate, d-amphetamine tannate (Nalertan tabules, Irwin, Neisler & Co.) one tablet every 12 hours. A list of drugs with clinical and gestational relationships is presented in Table 1.

Case Report of Child

The subject of this report, a male infant, was delivered after an uncomplicated pregnancy of approximately 278 days, during which there was a maternal weight gain of 21½ lbs. At the time of birth the infant was noted to have multiple red-black, slightly raised nodules on his face, chin, back, arms, legs, feet and fingers (Figure 1). These were originally believed to be hemangiomata. The liver was slightly enlarged.

On the day of delivery the hemoglobin was 14.4 gms. per 100 ml., and the hematocrit reading 42%. The nucleated blood count was 151,450 per cmm, as determined by electronic cell counter technic. There were 11 nucleated erythrocytes per 100 leukocytes. The platelet count was 129,600 per cmm by the phase microscopy technic. The differential count revealed 12% lymphocytes, three percent monocytes, 16% myelocytes, 43% blast forms, 13% polymorphonuclear leukocytes and 13% stabs.

A bone marrow examination was performed which was interpreted as repre-

RELATIONSHIPS OF DRUGS AND INFECTIONS TO STAGE OF GESTATION

Chronology from approximate date of conception.	Clinical Events	Medications
Minus 44 days	Ringworm, right leg.	2-dimethylamino-6-(beta-diethylaminoethoxy) benzothiazole dihydrochloride, (Asterol), topical.
Minus 41 days	Febrile, muscle pains, pharyngitis.	Oxytetracycline, (Terramycin), orally. a-d-4-dimethylamino -1, 2 diphenyl-3 methyl -2 propionoxybutane hydrochloride (Darvon), orally.
Minus 33 days	Ringworm unimproved.	25% glyceryltriacetate in an emollient base, (Enzactin cream), topical.
Suspected date of conception	End of last normal menstrual period eight days prior.	
Plus 48 days	Pregnancy suspected.	
Plus 53 days	Acute rhinitis, febrile, chills.	Oxytetracycline, (Terramycin) 100 mgm. and orally.
Plus 79 days	Pregnancy clinically confirmed. Nausea and vomiting.	Meclizine hydrochloride, (Bonine). "Prenatal" vitamin capsules (brand unknown), orally.
Plus 145 days	Otitis media.	Potassium alphaphenoxyethyl penicillin, (Syncillin), orally. Phenylephrine hydrochloride with chlorprophenpyramidine maleate, acetylsalicylic acid, acetophenetidin, and caffeine, (Novahistine with APC), orally. Salk poliomyelitis immunization, intramuscular.
Plus 179 days	Laceration of finger.	Formaldehyde-detoxified tetanus toxin, preserved with an organomercurial, thiomersal, (Tetanus Toxoid), 1.ml., intramuscular.
Plus 244 days (approx.)	Upper respiratory infection.	Penicillin 1 m., (penicillin G tablets), orally. Pyrilamine tannate, chlorpheniramine tannate, d-amphetamine tannate, (Nalertan tabules).
Plus 278 days	Delivery: leukemic infiltration of skin of infant.	

TABLE 1



FIGURE 2
SKIN BIOPSY, taken when the baby was 2 days old, showing infiltration of middle and lower dermis by abnormal and immature cells similar to those seen in bone marrow (X150).

senting either acute myelogenous leukemia, or leukemoid reaction. A biopsy was obtained from one of the skin nodules which grossly was an elliptical segment of skin 1.5 cm. in greatest dimension, with a firm grey-white nodule 0.7 cm. in diameter in the deeper dermis. Microscopically, the skin was infiltrated by immature myeloid cells in the corium and subcutaneous fat. This was interpreted as a leukemic infiltrate of the skin (Figure 2).

Two days after birth, the corrected nucleated cell count in the peripheral blood was 82,710 leukocytes per cmm. On the third day it was 92,860 leukocytes, and on the fifth day 85,120 leukocytes. Immature and abnormal leukocytes were seen in each of the peripheral blood smears on the days the counts were performed. The patient was discharged from the hospital with a slight weight gain.

Two weeks after birth, a consultant* noted an enlargement of the liver 3 cm. below the right costal margin, but no enlargement of the spleen. The skin nodules had faded, and were now confined largely to the face, although one or two were noted on the lower extremities, and the infant seemed well. Laboratory findings by the consultant revealed that the leukocyte count had fallen to 21,340 per cmm. with a differential count of two percent polymorphonuclear leukocytes, two percent myelocytes, two percent myeloblasts, three percent basophils, 14% lymphocytes, 77% monocytes and one erythroblast per 100 leukocytes. The platelet count was 165,000 per cmm., and the hemoglobin 13.7 gms. per 100 ml. The consultant believed these findings represented, in all likelihood, a leukemoid reaction.

The total white blood count values are presented graphically in Figure 3.

After the tenth month the family moved to another city, so that further clinical examination was not possible, but clinical information was available from the family. No therapy was given until the age of 11 months when the infant developed diarrhea and fever and was admitted to a hospital. The child had quite quickly developed a proptosis and a mass in the abdomen, and died at the age of 11 months, and 2 days. The final diagnosis as disclosed to the family physician was congenital acute blastic leukemia with involvement of the gastrointestinal tract, myocardium, lymph nodes, pancreas, bone marrow, skin, dura and arachnoid tissues. It is said that the thymus was not identified. The significance of the atrophy or absence of thymus is unknown, but it is well recognized that infections and malnutrition cause a rapid reduc-

*The authors wish to thank Drs. R. O. Butz, R. A. Henderson, and M. H. Gustafson of Muncie, and Dr. Robert J. Rohn of Indiana University Medical Center, Indianapolis, for their consultations in this case.

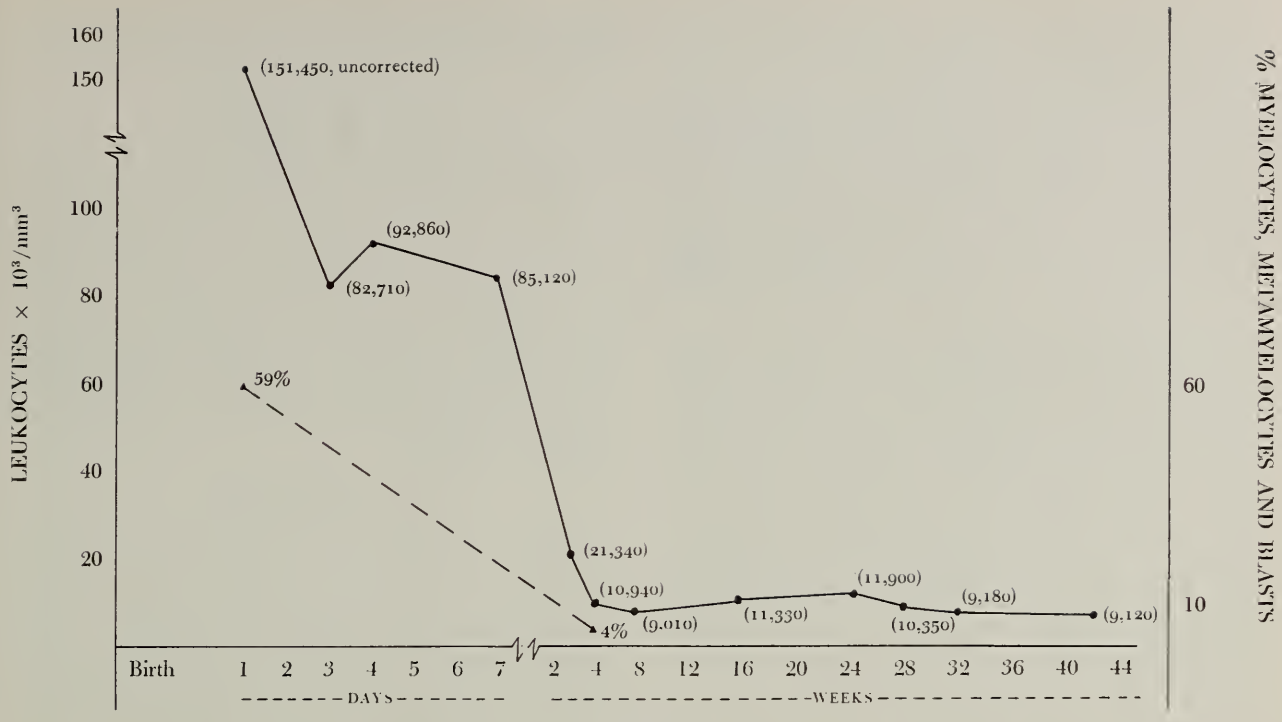


FIGURE 3

CHANGES IN PERIPHERAL white blood count during course of disease, showing remission after first two weeks (left abcissa). Percentages of immature myeloid cells in peripheral blood are shown on right abcissa.

tion in the weight of the thymus.[4] The autopsy findings will presumably be reported separately, by others.

Discussion

This infant is believed to have had the longest spontaneous remission and longest survival, with or without therapy, of any case diagnosed as congenital leukemia so far reported. For an excellent review and classification of leukemia in the neonatal period, the reader is referred to Pierce's comprehensive article,[3] where 19 of the 21 infants exhibiting clinical signs of the disease at birth had myelogenous leukemia and the remainder lymphocytic leukemia. In this group 10 of the 21 infants were born with nodular skin infiltrates. In all the infants in whom the hemoglobin and erythrocyte values were determined shortly after birth, the values were within normal limits, but fell rapidly thereafter. The duration of life in this group of infants was less than two weeks in eight of 21 cases, and less than two months in the remainder of the group. At the present time there are approximately 50 reported cases of congenital leukemia known to the authors. Skin nodules are known to be an important clinical sign.[5]

It has been suggested that congenital leukemia is the result of some injury occuring to the embryo between the sixth and ninth weeks and the injury is manifested in the hematopoietic system.[2] Indeed, in this infant, the mother suffered from symptoms highly suggestive of an upper respiratory viral infection approximately 53 days after conception.

Another factor which must be considered as a possible cause of congenital leukemia is ionizing radiation.[1] Neither mother nor infant was exposed to radiation during the pregnancy in this instance. Whether prior exposure of the mother or father to radiation is of significance is unknown, and at this time unknowable, although disease due to altered chromosomes from radiation or other cause must, by laws of probability, manifest itself in small but finite numbers of cases.

Drugs also deserve attention. In view of the occasional occurrence of disease following the use of pharmacologic chemicals, of which phocomelia following the use of thalidomide is a recent dramatic example, chemical effects following the use of frequently prescribed drugs must be seriously considered. It is obvious that the mother of

the infant was treated with a number of commonly used medications during or immediately before pregnancy and it is possible that one or more of these medications may have been in some way related to the disease. It is also possible that the patient used other nostrums or medicines, or was affected by some common household chemical thought to be harmless. These facets of the clinical history are beyond pursuit.

The maternal history of this case would suggest that fruitful lines of investigation of congenital leukemia would be further study of the relationships of infection, radiation and medication experienced by a mother (or father, in the case of radiation) before or during pregnancy, to aberrations in the hematopoietic systems of the embryo and fetus.

Summary

The case of a child born with myelogenous leukemia is presented. It is believed to be the longest known survival of a child born with this disease, 11 months, 2 days. A detailed summary of the prenatal care of the mother is given and the temporal relationships between viral-type diseases and drugs given during the pregnancy are presented.

Acknowledgement

The authors wish to thank Lall G. Montgomery, M.D., for help in obtaining a copy of the autopsy protocol and for critical review of the text; John B. Jewell, M.D., Ayerst Laboratories and Donald B. Clark of Roche Laboratories for supplying product information; and Dr. Thomas Laipply and Dr. S. Webster for allowing us to see the autopsy protocol.

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Toxicity Testing

An accusation levelled against the pharmaceutical industry which is of a much more serious nature than that of seeking excessive profits and which recently had a wide echo in consequence of the thalidomide tragedy, is that the industry, in order to make quick profits, is callously launching new drugs too rapidly, without subjecting them to a sufficiently prolonged and careful toxicological testing.

Whoever is familiar with the exceedingly painstaking and elaborate system of pharmacological testing of a new drug routinely practised in the laboratories of any pharmaceutical firm of repute before it is released for clinical use, knows that there is no substance in this accusation. Naturally, misfortunes such as that of the thalidomide tragedy cannot be completely avoided because it is always possible that even with the most careful testing on animals a drug may exhibit some toxic effect on man in certain conditions which cannot be reproduced in animals.—The Trueman Wood Lecture by Ernst B. Chain, F.R.S., *Journal of The Royal Society of Arts*, London, Oct., 1963.

Treatment of Orthostatic Hypotension With 9-alpha-fluorohydrocortisone*

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BRADBURY AND EGGLESTON[1] first described the syndrome of orthostatic hypotension in 1925. Since then, no generally satisfactory mode of therapy for the condition has been found. Treatment in the past[2-5] has consisted of elastic supports applied over the entire abdomen and lower extremities, application of an anti-gravity suit, Ephedrine, desoxycorticosterone acetate (Doca), and the head-up bed, either alone or combined with a high intake of salt.

Hickler and co-workers[6] reported that 9-alpha-fluorohydrocortisone treatment was more effective than any of the above mentioned methods. Schirger et al.[7] reported satisfactory symptomatic control in five of six patients treated with this drug. In one patient in their series, the rise in blood pressure obtained within 48 hours after beginning treatment was accompanied by increased sodium retention and potassium excretion. No major alterations in water and electrolyte balance persisted on long term observation.

Schneider[8] reported the case of a man who had three "black-outs." The patient noted some giddiness during the first hour or two after arising in the morning and observed that his bathroom light seemed to grow dim while he stood shaving. His blood pressure was 95/55 supine and 55/0 standing. A therapeutic trial of 9-alpha-fluorohydrocortisone increased the patient's standing blood pressure to 150/90 with a weight gain of seven lbs. in 10 days and the appearance of a 1+ pretibial edema.

After the administration of Mercuhydrin, he lost 10 lbs. in three days with a fall of standing blood pressure to 45/0; then for the first time, symptoms of confusion and agitation became manifest on standing. Thereafter, the dosage of fludrocortisone was adjusted to a point just short of causing ankle edema, about 0.05 to 0.1 mgm. daily. A casual standing blood pressure on discharge was 110/80, and the patient continued on this regime for the next six months with subjective improvement and diminution of morning dizziness and hazy vision. He had three more transient syncopal episodes at times when he omitted his medicine because of increasing ankle edema. A combination of the head-up bed for sleeping and fludrocortisone then achieved smoother control.

The term "orthostatic" or "postural" hypotension has been used in the broadest sense for any excessive fall in blood pressure on assuming the erect position. Idiopathic orthostatic hypotension, according to some criteria, is based on the presence of a reproducible fall in blood pressure, extensive anhydrosis, the presence of impotence in males and absence of conditions known to cause so-called secondary orthostatic hypotension. Examples of the latter are pregnancy, nitrite administration and other iatrogenic causes (certain tranquilizers and psychic energizers, for example) sympatholytic drugs such as those used in the treatment of hypertension, sympathectomy[8], and cases associated with certain neurological diseases, particularly diabetic neuropathy and tabes.

Three of my patients with idiopathic orthostatic hypotension were studied for the effects of treatment with fludrocortisone. In all three, blood pressure elevation and relief of symptoms occurred.

Common complaints were dizziness and faintness in the group reported here. The symptoms lasted for a few minutes and nearly always occurred when the patient was standing erect. It is my belief that there are wide variations in the severity of dif-

*9a-fluoro-17-hydroxycorticosterone-21-acetate or fludrocortisone (Florinef Acetate), E. R. Squibb & Sons, New York, N. Y.

ferent cases of orthostatic hypotension, and in the multiplicity and character of the symptoms.

Case Report I

The patient, a 55-year-old postal clerk, was first seen on February 6, 1962. He complained of dizzy spells of two weeks' duration, and of feeling considerable fatigue. He also had been sleeping for several hours longer than usual. On April 2, after tranquilizers had produced no improvement, he stated that he had had to hang onto objects while talking to people and had had to discontinue his work. Dizziness, tachycardia and blurring of vision appeared when he stood or sat. His wife had found him on the floor once—he had not fallen but said he could not take another step. On one occasion he had diplopia.

X-ray study of the skull was negative. An electrocardiogram was normal. Carotid sinus pressure failed to produce the features of the syndrome nor were there alterations of the electrocardiogram during carotid sinus pressure. Chest x-ray was negative.

Some representative blood pressure readings were 125/90 reclining; 130/90 sitting and 90/70 after he had stood for two minutes. Triamcinolone was of no benefit. The head-up bed advocated by MacLean and coworkers[1] produced only slight improvement. ACTH was administered in dosages of 40 and 80 units and brought about considerable improvement in well-being.

On 10/25/62, the patient was started on fludrocortisone in doses of 1 mgm. twice daily for four days, then the dosage was reduced to 1 mgm. daily. By 11/15/62, he stated that he had had no episodes of vertigo whatsoever, was not so tired and he had become somewhat "pudgy," particularly around his abdomen. Blood pressure was 160/100 reclining; 150/98 sitting and 150/90 standing. He felt as if he were progressing for the first time in a year.

By 1/10/63 he reported no symptoms of hypotension. Blood pressure was 160/90 reclining; 170/110 sitting; 130/85 standing and 130/90 after standing for three minutes. The dosage of fludrocortisone was reduced to .3 mgm. By 6/13/63, his reclining blood pressure was found to be 180/100; sitting 170/110; standing 150/90, and after standing three minutes 140/90. Dosage was then reduced to 0.2 mgm. a day. He has felt well since and has been edema free. On 8/20/63, reclining and standing blood pressures were still 165/100 and 160/100 and the dose was reduced to 0.1 mgm. daily.

Case Report II

The second patient was a 25-year-old housewife and mother of three children. She was seen on January 5, 1963, with symptoms of tachycardia, fatigue and sensations of faintness, dizziness and weakness on getting up. When she stood for a time she felt as if she might lose consciousness. Sitting or lying down relieved her symptoms. There was some dyspnea upon walking considerable distances. At times there was a feeling of numbness below one elbow and she also complained of headaches. She believed that she had fatal heart disease.

Physical examination was unrevealing except for the abnormalities of her blood pressure readings. The blood pressure was 130/80 reclining; 124/90 sitting; 110/100 standing and 94/75 after standing for three minutes. The pulse rate was 96, and the beats were considerably fainter when she had been standing for a time. Fludrocortisone was administered in a dosage of 2 mgm. daily for four days, and thereafter lowered to 1 mgm. daily. After five days of treatment, the blood pressure readings were 120/80 lying; 110/88 sitting; 115/80 standing and 110/80 after standing for three minutes. She stated that she felt much better, particularly as to the headaches and vertigo. She was in much better command of herself, was more self-assured and serene, and simply looked much better.

By 6/18/63, she was pitching for a girls' softball team, in addition to performing her household duties. Blood pressures were 114/70 reclining; 112/72 sitting; 112/88 standing and 115/85 after standing for three minutes. The maintenance dose of the drug had been established at 0.5 mgm. a day.

Particularly striking in this case, as in the others, was that the auscultation sounds in the antecubital fossae were particularly weak while the patient was standing prior to fludrocortisone administration. They were strong and clear after administration

of the drug. Pulse pressures obtained while patients were standing were also lower, in general, than those obtained after administration of the drug.

Case Report III

A 52-year-old housewife with a long history of asthenia telephoned to state that she was so dizzy that she "couldn't stand up." She was seen at home on April 6, 1963. She had lost 35 pounds in three months, was suffering from headaches and abdominal pain, but most of all from dizziness and near-syncope when she assumed the erect position. Blood pressure readings were 120/80 reclining; 92/70 sitting and after 1½ minutes of standing, the blood pressure was unobtainable.

She was placed on 2 mgm. a day of fludrocortisone. On 4/9/63, she said that this was the first day on which she had been able to stand up comfortably. Blood pressure readings were 130/90 reclining; 124/92 sitting; 95/85 standing (the beats were a bit faint) and 130/90 after standing for three minutes. The dosage was lowered to 1 mgm. for one week after which she was to lower the dose further to 0.5 mgm.

By 5/2/63, she felt well and had gained 12 pounds. The blood pressure readings were 182/88 reclining; 192/102 sitting; 162/100 standing and 170/100 after standing for three minutes. Maintenance dose on 6/3/63 was 0.4 mgm. and readings were 160/90 reclining; 144/100 sitting; 136/90 standing and 142/90 after standing for three minutes. (As time goes by, the dosage is lowered progressively in these patients until the blood pressure assumes normal levels.) On 8/29/63, the reclining blood pressure was 190/96 and after two minutes' standing it was 180/100. As she still complained of headaches, the dosage was reduced from 0.2 mgm. to 0.1 mgm. daily.

Comment

The mode of action of 9-alpha-fluorohydrocortisone in preventing the fall in blood pressure is not known. Salt and fluid retention, as well as expansion of intravascular and extra-cellular fluid volumes, may play a part. Some observers believe that release of norepinephrine may be faulty in orthostatic hypotension. It has been shown that the effects of epinephrine and norepinephrine in man are potentiated by desoxycorticosterone acetate, a compound similar to 9-alpha-fluorohydrocortisone. The absence of serious side effects has, to date, been noteworthy. However, it is a potent compound, as has been shown by its action in Addison's disease and orthostatic hypotension. The occurrence of elevation of blood pressure to more than normotensive figures in some of our patients before dosage was cut down is adequate reason in itself for close observation.

Conclusions

1. 9-alpha-fluorohydrocortisone was found to be effective in relief of symptoms and elevation of blood pressure in three patients with orthostatic hypotension.

2. It is believed that orthostatic hypotension occurs more frequently than has been generally supposed. It is necessary to be alert to the possibility of its existence when patients complain of dizziness, faintness, near-syncope and syncope. Estimation of the reclining blood pressure, the pressure on standing and the pressure on standing for three minutes will reveal the presence of the condition. Vertigo is a common symptom although its origin is frequently obscure. Accurate diagnosis of orthostatic hypotension combined with successful treatment would greatly reduce the number of sufferers from this troublesome complaint.

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Indianapolis

From *The Journal* 50 Years Ago

. . . The Robert W. Long Hospital of the Indiana University School of Medicine, Indianapolis, was formally dedicated on Monday, June 14, 1914.

* * * *

Dr. J. N. Hurty was toastmaster and speeches were made by Dr. Pritchett, Dr. Bryan, president of the university and Dr. Hoover, professor of medicine, Western Reserve, Cleveland, Ohio.

The day was a beautiful one and the whole series of events carried out on schedule to the great satisfaction of those fortunate to attend them.

Great interest attaches to the address of Dr. Pritchett, because he is peculiarly qualified by reason of his observation and close study to discuss the subject he chose, "The Medical School and the State." He made no attempt to eulogize this particular school, or to discuss the local situation further than to say that he believed a correct start had been made to build a medical institution of merit and great value to the state.

Broadly speaking, his idea is that the chief function of a medical college maintained by the state is to conserve the health of the people of the state.

The medical college should be one of the big factors, classed with the State Board of Health, State Pathologic Laboratory, State Hospital, and other agencies related directly to the health of the people and under control of the state. These units should work in harmony—the ultimate aim being a single one—conservation of the health of all the people of the state. Broad but efficient and practical public service should be the keynote of the ideals which should prevail in the administration of a medical institution supported by the state. . . . "The Dedication of The Robert W. Long Hospital," *JISMA,* July, 1914.

The Case of the Lepromatous Leprechaun

ARNOLD LIEBERMAN, M.D.
New York, N. Y.



NOT ALL SICILIANS ARE, of necessity, Mafiosi; not all blatantly obvious observers of Kashruth are, of necessity, pious frauds. Unfortunately for Carlos Rici, he stemmed from just such a union. His mother was widowed when a very minor Brooklyn hoodlum, a "soldier" in the Cosa Nostra, was liquidated in the course of some long forgotten feud between a couple of Lucky Luciano's henchmen. Rici's widow presided over a little restaurant that was actually a house of assignation. She also birthed a couple of whelps whose fatherhood was a bit uncertain for reasons that need no further detailing.

Now Chaim Shmulik—this name will do —was one of those unbathed, payse flaunting, black hatted Brooklyn Williamsburg super orthodox Hebrews who (in my frankly bigoted opinion) was no ornament to his congregation. Chaim, between laying twillen, attending shul and running a kosher meat market, found time to pay court to such females as the widow Rici. It was a rather open neighborhood secret that Carlos had been fathered by Chaim. As the boy grew, the facial resemblance gave unmistakable confirmation to common gossip. Still, Carlos went by his mother's name and was reared a Catholic. The shul members held that as a black mark against Chaim even if they shrugged off the shikse philandering. On this matter I have no prejudice.

I *do* know that Carlos Rici sprouted like a noxious weed in a terrain of laissez faire juvenile delinquency. He even violated all the mores of the wolf pack he had joined. No school could hold him long enough to teach him anything. Even in the reformatory, he had been isolated as too depraving an influence on the other, less unregenerate inmates. To pander at the age of six was *not* good kindergarten morals—no matter how often Madam Rici went to confession or how often Chaim intoned the Shma at the synagogue. To pick pockets and snatch purses at eight was more than a just a blot on the police records of the precinct. To be a heroin runner did not help; to carry a shiv and a stolen revolver at 12 — well! Why belabor the point? At 16, Carlos was implicated in a mugging AND a murder; he managed to skip Brooklyn and stow away on a banana ship to Columbia.

A Cacoethetic Cugat

In Barranquilla, Bogota and Cali, Carlos passed for a mestizo*; he made a living, of a sort, playing percussion instruments in a band. This passion for music making was about the only visible redeeming feature possessed by the unregenerate urchin. Only five feet tall, he was a muscular menace

* A person of mixed blood. (In Spanish America, one who has Spanish and American Indian blood).

with the knife and the garrote; with the drums, he was a genius! Self-taught, he could crouch over the tympani and beat out a jungle tattoo that invariably "sent" the hep-cats wild. The sullen, coldly glowering, habitually menacing scowl became transfigured into a rapt, rhythmic, rapture reaching for rhythm that somehow gave his countenance an appealing, trance-like quality. This native talent could have made Carlos Rici another Xavier Cugat were it not for the other, already catalogued, aberrations of his character.

Even Colombia got too hot for Carlos; he went on to Puerto Rico; then, he drifted back to New York. Under another name, he became a drummer in a Greenwich Village cafe band. He learned to blend into the background; he managed to avoid the police. He did NOT contact his mother; he did not even cross the East River to Brooklyn. He was now Castro Hernandez, the Puerto Rican: and that was that!

For some six years he did very well, indeed. The village beatniks held him in high esteem; the cafe visitors doted on his playing. His male and female amours were not flaunted too outrageously. The eager, unshaven and unwashed face poised over the drums was part and parcel of the cafe atmosphere. The tangled, unkempt locks and the long, dexterous fingers flying over the tympani beat out magical, primitive rhythms evoking ecstatic, swooning responses. A visitor, more literate than most, once exclaimed, "That guy is a real, honest to goodness *LEPRECHAUN!*" Indeed, the crouching slinkiness did resemble a pigmy sprite, (as long as one stayed to windward of the figure.) The name was descriptive of the man and it stuck; our friend became the "Leprechaun of the Blah Cafe": another quaint item of village bizarrerie.

This brings us to the spring of 1963 when Carlos Rici was stricken by inexplicable misfortune. Now thirty years old, the drummer began breaking out in a slowly progressing but inexorably spreading skin rash. He went to the out patient department of a near-by hospital where he was treated for scabies and ringworm that were found in skin scrapings. Both diseases were controlled readily but—to the surprise of the dermatologists—the assorted eruptions did not clear: they continued on their worsening way. Not many months later, his entire face became covered by a conspicuous and hideous rash. Public appearances became an impossibility as visitors began to shrink away from something so obviously contagious; the cafe management was truly sorry but it had to let him go.

With typical Manhattan logic, he was given a job as a dishwasher. In his off hours, Carlos commenced a tour of various city clinics. He had a little money but it never occurred to him to go and see a doctor privately. There may be a moral in this reluctance to visit a private practitioner; let us not get diverted discussing modern medical trends. In any case, six months of assorted treatments did no visible good. Finally, in his peregrinations, Carlos Rici came to the hospital with which I happen to be associated.

The chief of dermatology described the lesions as, "pea to bean sized, firm, nodular, non-pigmented and not tender." There had been no fever, night sweats, cough or shortness of breath. There had been no anorexia or malaise even though the patient thought he had lost four to five pounds in weight. Carlos denied any tuberculosis, diabetes, asthma, allergies or any other illness. He stated that he had never had a sick day in his life.

Physical examination showed a well nourished, powerfully built, squat individual in no distress of any kind. Blood pressure, temperature, pulse, heart, lungs and abdomen were recorded as being entirely unremarkable. There were no lesions in the mouth, pharynx or hard palate. Neurologically, nothing significant was observed. All of the positive findings were limited to the skin and lymph nodes. The closely spaced maculopapular eruptions involved the entire body surface (Figure 1). The doctor palpated several small, rubbery, not tender glands in the right axilla and both groins. The usual and unusual laboratory tests added very little: the erythrocyte sedimentation rate was only five; the VDRL was negative; all blood sera determinations, including the liver profile, were normal. The chest x-ray was read as being within nor-



FIGURE 1
CLOSELY SPACED maculopapular eruptions shown on the patients upper arm. These eruptions were present over the entire body surface.

mal limits. However, the bone survey films came up with "suggestive shadows in the capitate and hamate bones . . . need further corroboration for diagnosis of *sarcoidosis.*"

Agromanic Ambulant

A snip of skin was sent to the pathologists; they identified the histological sections as "granulomatous inflammation . . . consistent with sarcoidosis." This is when I was asked to admit the patient to the ward for further observation. The dermatologists were puzzled by the bizarre manifestations of this case of sarcoidosis; they did not quite accept the diagnosis—microscopic sections notwithstanding. When I looked at the lesions (Figures 1 and 2) I gave passing thought to this being a neurofibromatosis, von Recklinghausen's disease. Somehow, however, it looked different! I had seen these lesions before but I could not recall just where. Skin cases in the otherwise healthy patient are rarely admitted to our crowded wards; this seemed like a good teaching problem that would be the exception; Carlos Rici was admitted under his pseudonym of Castro Hernandez.

As he had no symptoms beyond the rash, no medication of any sort was prescribed for him and he was given the run of the floor. There was something forbidding about this "loner;" the other patients gave him a wide berth. He watched TV and ate his meals heartily plus all the fruit he could lay his hands on.

A second and a third skin biopsy took generous slices from his arm and abdominal wall. He submitted to the procedures under local anesthesia with taciturn stoicism. Our resident pathologists were a bit confused as to what they saw on the Hematoxylin and Eosin sections; they sent the slides to a very famous consulting pathologist who specialized in dermatology. This luminary called the sections "consistent with multiple, disseminated xanthomatosis" (Figure 2). Then he went into a rather patronizing discourse on the differential diagnosis of lipoidoses.*

My late revered teacher, A. J. Carlson, had a perennial quip that is worth recalling. "If you say, 'I don't know', in three words, you flunk; if you say it in three volumes, you become a professor." Of course, I had glimpsed Carlos on ward rounds; I had been shown the learned consultation note after I had gone up to the pathology department to inspect the slides. I still did not know what ailed our enigma but there was a stirring unease in the back of my mind. I went back to my 1944 edition of Ormsby's text on *Diseases of the Skin.* On page 995 of that beautifully illustrated monograph, I read that "these Virchow cells are essentially histiocytes that have undergone lipoid and vacuolar degeneration so that the individual cell naturally resembles the foam of a *xanthoma* cell. . . ." Looking further, in the third edition of Lever's classic text *Histopathology of the Skin,* I was not surprised to read on page 243 that, "Virchow cells . . . are large, foamy cells resembling those of a *xanthoma.*"

Monographs under my arm, I went to see the chief of pathology. He was still smarting a bit over a recent near fiasco (Case of the Fumbled Fungus *JISMA,* 57:8, 1017-1022). It did not take us long to go down to the ward and corral Carlos Rici for still another inspection. During our painstaking examination, the pathologist performed a clinical maneuver overlooked by all the clinicians. He palpated firmly in the sulcus of the humerus, "the crazy bone," through which the ulnar nerve runs. The patient did not even

*1. Systemic lipoidoses with increased serum lipids;

2. Systemic lipoidoses with normal serum lipids (Hand — Schüller — Christian group, Niemann-Pick diseases, Gaucher histiocytoses);

3. Cutaneous lipoidoses with normal serum lipids: extra-cellular cholesterolesis, necrobiosis lipoidica, xanthelasma palpebrarum, necro-xantho-endotheliomа, etc.

flinch. "I think that this nerve is definitely thickened," my friend remarked, quietly. It was! And yet, over the area of its distribution, sensation was diminished very slightly, if at all!

We had both read the passages in the text books that I had marked; we were on the lookout for the hallmarks of this particular disease. Still, credit should go where it belongs. This time, deep and generous skin scrapings were taken. The usual Ziehl-Neelsen stain was not considered sensitive enough; Wade's modification of the Fite-Faraco procedure was used. The results were very spectacular, indeed! Whole packets of *Mycobacterium leprae* were seen. When sought, the correct answer was there!

Hygiene vs. Hansen's

Because of the frightful, obvious disfigurement produced by leprosy, it has been a disease feared and shunned by all the world's peoples since the beginning of recorded history. It attained its epidemic peak in the Europe of the 11th to 13th centuries. The leper of medieval times had to toll a bell as he walked along the highway or village street; this was to warn the populace of his approach. In English churches, one can still see the *hagioscope* (hagios, holy); this is a slit in the brick through which the leper could squint to see the sacrament at the altar.*

My personal experience has been limited to less than a score of cases: only *one* picked up in private practice. The disease continues to be rather common between the 30th parallels of the globe: it is estimated that some one percent of the people of the tropics are still afflicted. The Board of Health of Greater New York knows of some 50 cases within its jurisdiction; practically all of them have a history of coming from warm climates such as Puerto Rico, Central America or southern Asiatic lands. My personal impression is that leprosy is a disease of *filth:* there has to be frequent and assiduous massage by the skin of a leper against the skin of the inoculee. In that sense, we can consider leprosy to be like *yaws:* not classified with the venereal diseases but acquired in a very similar fashion. About the only precaution taken by experts who handle lepers is simple *cleanliness.* A thorough hand scrub after contact is considered enough. My reading makes me suspect that the flare up of leprosy in Europe following the dislocations of the Crusades was abetted by an increase of the usual filth in which the populace wallowed. Modern hygiene, i.e., simple soap and water, has reduced leprosy in advanced nations to the vanishing point; it will do the same for the backward nations as they catch up.

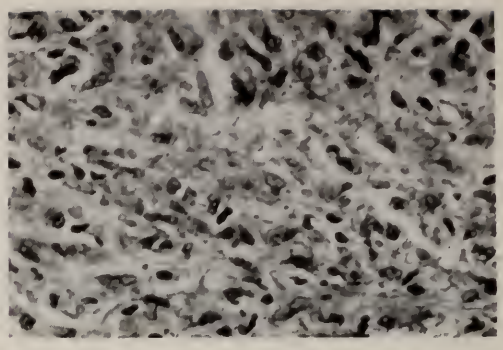


FIGURE 2
H & E STAINED skin biopsy diagnosed as being consistent with multiple disseminated xanthomatosis.

Of course, the experts may be also right in stating that there are great *racial* variations in susceptibility to the disease. Thus, it is asserted that Hawaiians are almost a hundred times more susceptible to Hansen's bacillus than are Europeans. This may be for the same reasons that measles (almost harmless to Europeans) decimated the Polynesians when they were first exposed to it. Or that Jews, as a race, display a high resistance to tuberculosis. Arnold resolves the argument by the suggestion that "leprosy is easily acquired by contact with lepromatous persons during periods of increased susceptibility to which some persons are subject." Also, it may be true that the ancient virulence has been subdued. Certainly, the skin of Castro Hernandez (or call him Carlos Rici) teemed with myriads of the organ-

*One can refer to several sources for detailed exposition of the topic. In 1963, there was a Ciba Symposium on *The Pathogenesis of Leprosy.* It is No. 15 of the series published by Little, Brown & Co.; Harry L. Arnold, Jr. put out a very authoritative volume on *Modern Concepts of Leprosy,* (Published by Charles C Thomas.) This same author has a most concise and well illustrated article in the 11th edition of *Cecil-Loeb* published by W. B. Saunders, 1963. For a crisp and inimitable summation, I know of nothing better than William Boyd's *Textbook on Pathology* (7th edition) published by Lea & Febiger.

isms; there were no clinical signs—as yet—of any ill effects beyond the tremendous rash. Of course, the thickened ulnar nerve was an infallible forerunner of inexorable systemic advance.

Leprosy has two general forms that may mingle and blend: 1) lepromatous type; 2) tuberculoid variety. Carlos had the first type. Hansen had isolated the organism as far back as 1874. The incubation period of this disease is of extraordinary length: five to 20 years is not an uncommon span. Many new cases fail to recall any contact with a leper. Much has been learned about this ancient plague; much remains to be explained.

Take as an example the lepromin or Mitsuda test. In concept it is exactly parallel to the tuberculin tests for tuberculosis. Yet a positive response does *not* connote the presence of the disease. On the contrary, it is an expression of *resistance* to leprous development. In the lepromatous variety, the test is usually negative; in the tuberculoid, positive. Now comes the puzzler! Use Bacillus Calmette-Guérin and vaccinate the negative reactor against tuberculosis; the previously negative lepromin response now becomes POSITIVE! In other words, one method of protecting healthy contacts with leprosy is to vaccinate them against tuberculosis! Granted that the causative organisms are both Mycobacteria and are closely related morphologically (and otherwise). Still, no one has come up—so far—with an answer to this most fascinating fact of cross-immunity: if that is what it is.

Leprosy continues to carry with it an aura of public repugnance. As we have indicated, the contagiousness of Hansen's disease is of a very low order. Furthermore, very adequate methods of treatment are being developed. Chaulmoogra oil has been almost entirely replaced by the sulfones and their esters. Dapsone and sodium sulfoxone are given with good results; the injections have to be continued for many months. Some work is being done with an oral preparation, sulfamethoxypyridazine; this tongue twisting medicament has to be continued for as long as two years but "remarkable clinical improvement" is being reported.

Not Lousy but Leperous!

All this learned discourse would have been totally wasted on Carlos Rici, our *Lepromatous Leprechaun*. We simply told him what he had and that he would have to go to the leprosarium at Carville, Louisiana for the needed treatment that would be protracted, even up to two years. The Board of Health was contacted and the wheels were set in motion. Carlos' stolid nature was an asset to the patient; or, was it just a lack of imagination?

During the ten days or so of waiting, we took only the ordinary precautions of screening his bed and having him use separate dishes and linen. I did wash my hands thoroughly after each stop at his bedside. His taciturnity did thaw a bit after he saw that we were not turning him over to the police; he may also have been unused to all the attention he received. I saw him daily and was able to extract a good deal of his life story that has been detailed above. On the very last day of his stay at our hospital, I got the story of his original contact. After he understood my question, the answer was straightforward. "In Colombia, I lived with a very good friend of mine. Yes! We were in *very* close contact! Come to think of it, he did have a lot of spots on him but we thought it was just from lice"

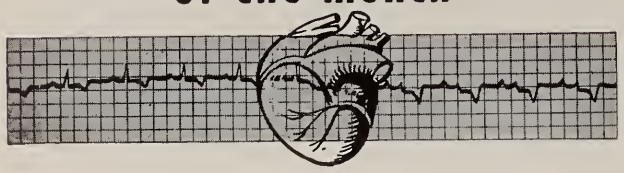
1270 Fifth Ave.
New York, N. Y. ◄

Dr. Arnold Lieberman's medical stories which have appeared in the *JISMA* are to be published as a collection in book form by Charles C Thomas, Springfield, Ill.

The volume, which will appear soon, contains nearly 360 pages, approximately 107 illustrations and sells for about $8.00.

Dr. Frank B. Ramsey, editor of *The Journal*, wrote the foreword and Dr. Howard A. Rusk, the prologue.

Electrocardiogram of the month



Presented as a regular feature of The JOURNAL, Electrocardiogram of the Month is a series of short talks on cardiovascular diagnosis and treatment, edited by the staff of the Krannert Heart Research Institute, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis.

Paroxysmal Atrial Tachycardia

CHARLES FISCH, M.D.
Indianapolis

PAROXYSMAL ATRIAL tachycardia is a common arrhythmia often seen in the absence of heart disease. The usual method of terminating the acute attack is to stimulate the vagus or to use vagomimetic drugs. The arrhythmia ceases abruptly and is frequently followed by a short period of standstill due to suppression of the normal pacemaker by the ectopic rhythm. In about six to eight percent of the cases, however, the tachycardia is followed by a run of ventricular arrhythmia (Figure 1).

The patient was an 81-year-old male who was seen with repeated episodes of paroxysmal atrial tachycardia. During one such episode an ECG (Figure 1) disclosed a rate of 223 beats per minute, R-R of 0.26 seconds which, with carotid stimulation, showed a gradual prolongation to 0.34 seconds, appearance of an aberrant rhythm, (apparently ventricular in origin) and finally conversion to normal S-A rhythm. ◄



FIGURE 1
ATRIAL TACHYCARDIA terminated with carotid sinus pressure.

X-RAY CONFERENCE

Presented as a regular feature of *The Journal*, X-ray Conference is a series of short talks on procedure and radiologic diagnosis, edited by Erich K. Lang, M.D.

Meatal Stenosis with Resulting Ureteral Reflux

ERICH K. LANG, M.D.*
Indianapolis

A NINE-YEAR-OLD white male had been repeatedly admitted to Methodist Hospital for recurrent urinary tract infections. At first, the management relied principally on urinary antibiotic therapy. At the age of two years, a meatal stenosis was diagnosed and dilatation was carried out. In spite of that, the patient suffered from frequent recurrent infections complicated by ascending pyelonephritis.

An intravenous pyelogram performed during this last admission revealed considerable blunting and irregularity of the calyces of the right kidney. This suggested a chronic pyelonephritis. No significant loss of renal parenchyma was, as yet, apparent. The most significant findings were noted on a voiding cystourethrogram (Figure 1). During low pressure distension of the bladder with some 60 cc. of contrast medium, there was reflux into both distal ureters and into the right kidney pelvis. During the high pressure and voiding phases, massive reflux into the right upper tract was observed. The prostatic urethra and, particularly, the anterior urethra appeared to be abnormally wide, undoubtedly secondary to the old meatal stenosis. A secondary bladder neck hypertrophy was observed. The nuda muscle was rather prominent.

The patient was placed on a program of continuous urinary antibiotic therapy and continued dilatation of the meatus. A bladder neck resection may be considered in the future management of this patient.

* Radiologist, Methodist Hospital.

Discussion

It is now generally agreed that ureteral reflux is abnormal and the ureterovesical junction should be competent during and between acts of micturition.

Considerable controversy has existed over the cause of ureteral reflux. Although obstruction of some sort or nature have usually been regarded as pertinent causative factors leading to reflux, infection of the urinary tract is probably the main etiologic factor. Mucosal and submucosal edema tends to disarrange the valvular mechanism at the ureterovesical junction and reflux may then occur. Undoubtedly obstruction at the meatus of the urethra, a valve in the midportion of the urethra, or bladder neck obstruction will enhance the probability of recurring infections in the bladder and thus cause ureteral reflux.

Method

The use of an image intensification system for this examination is mandatory. The dose delivered to the gonads of the patient has to be kept at a minimum, particularly since this examination may frequently be repeated.

The patient is placed in a supine position and a disposable Foley catheter is introduced into the bladder. Radiopaque medium



FIGURE 1

NOTE THE MARKED REFLUX into the right ureter and right kidney pelvis. There is minimal reflux on the left side. A typical secondary bladder neck hypertrophy is seen as a ring-like constriction at the level of the bladder neck.

is instilled. The procedure is carefully monitored fluoroscopically and intermittent recordings on cine films are obtained. Minute reflux is often seen only on these cine recordings and may be missed by the fluoroscopic observer. Recordings are obtained in the anterior position as well as both semi-oblique positions to demonstrate the distal end of the ureters which enter the bladder in the posterior plane.

The patient is assessed for reflux under low pressure distension, high pressure distension of the bladder and during the voiding phase. Separate cine runs of each of these three phases should be obtained. The voiding phase is best recorded in a semi-oblique position demonstrating the entire urethra and the bladder neck. For small children, the use of a customary device (potty) is often necessary to prompt the child to void. The voiding phase is particularly scrutinized for primary or secondary bladder neck hypertrophy, urethral valves and for meatal stenosis. Low, high pressure and voiding phases are also assessed for ureteral reflux. After completion of the examination, both kidney areas are scanned for residual dye. Residual dye in the bladder is likewise assessed, allowing a conclusion to be made as to incomplete emptying and/or urinary retention.

The procedure, while time-consuming, will yield extremely valuable information and the cause for recurrent urinary infections can usually be diagnosed. Utilization of modern image intensification systems, either of the optical or television variety, will reduce the dosage delivered to the patient to realistic values. A total dose of one and one-half to six roentgens should be the limit delivered during such a procedure. Demonstration of the various phases on single spot films necessitates considerable dexterity on the part of the observer and is difficult to reproduce consistently. ◄

LABORATORY MEDICINE

This page reviews established or relatively new but reliable laboratory procedures for physicians in general. It is not designed for specialists and laboratory personnel who would desire more technical information.

Identification of Fetal Erythrocytes in the Maternal Circulation

*WEI-PING LOH, M.D.**
Gary

THE IDENTIFICATION of fetal erythrocytes in the maternal circulation is essential to the diagnosis of transplacental hemorrhage which often causes severe nonhemolytic anemia in the newborn.[1] This procedure also has value in the evaluation of blood group isoimmunization which causes hemolytic disease in the newborn.

The principle in this procedure is based on the difference between the fetal hemoglobin and the adult hemoglobin.[2] Fetal hemoglobin (hemoglobin F) is more resistant than adult hemoglobin (hemoglobin A, sometimes S and C) to denaturation, not only in alkali but also in acid.[3] Thus, at an acid pH of 3.5, the adult hemoglobin will be eluated from the maternal erythrocytes, but fetal hemoglobin will remain in the fetal erythrocytes and can then be stained and quantitated.

Method

1. Draw a small venous blood sample from the mother, using sodium EDTA as the anticoagulant.
2. Dilute the blood with an equal volume of 0.9% sodium chloride.
3. Make thin blood smears and dry in air. Write the patient's name on the smears with a diamond pen.
4. Prepare a positive control smear in the following manner:
 a) Obtain two drops of fresh blood from the cord of the newborn and wash with normal saline two to four times.
 b) Mix the cord blood with fresh sodium EDTA anticoagulated adult blood of a type compatible with the cord blood.
 c) Make a thin blood smear, air-dry and mark the smear as "positive control."
5. Prepare a negative control smear from any normal adult blood.
6. Fix all smears in 80% ethyl alcohol for five minutes.
7. Wash gently with distilled water and air-dry.
8. Immerse the smears in a citrate phosphate buffer, pH 3.5, and incubate in a 37° C water bath for five minutes. The citrate phosphate buffer must be made up fresh in the following manner and maintained at 37° C when it is used:
 a) Citric acid monohydrate — 1.4647 gm.
 b) Na_2HPO_4 — 0.8601 gm.
 c) Mix the two chemicals and make up to 100 ml. with distilled water.
9. Wash the smears gently with distilled water.
10. Stain with Harris acid hematoxylin for

* Chief Pathologist, Methodist Hospital of Gary; Assistant Professor of Pathology, Chicago Medical School.

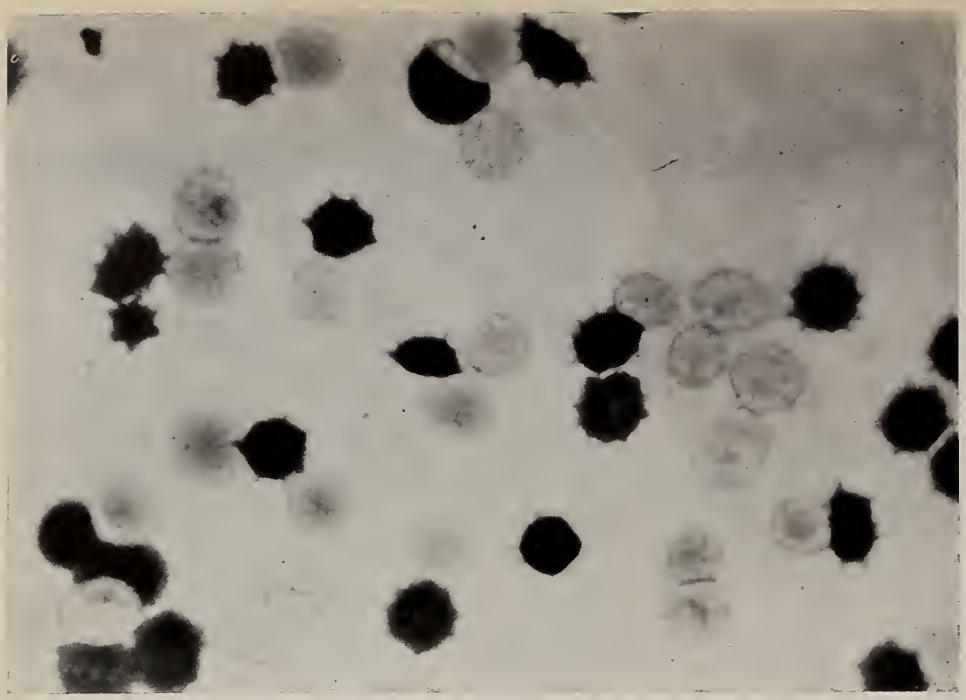


FIGURE 1
NOTE THE ADULT (maternal) erythrocytes in the form of faint ghost cells and the fetal erythrocytes in the form of solid dark cells. Their crenated appearance is due to artefact (approx. 3000X).

five minutes.
11. Wash in distilled water gently but completely.
12. Stain with Erythrocin B (eosin), 0.5% aqueous solution, for five minutes.
13. Wash in running water for one minute and air-dry.
14. Mount with coverslips.

Interpretation

The maternal erythrocytes containing adult hemoglobin appear as faint ghost cells (Figure 1). The fetal erythrocytes containing fetal hemoglobin stand out clearly as solid pink cells and the amount of fetal hemoglobin may be quantitated. A recent report indicates that as little as one drop of fetal blood in the entire maternal circulation may be detected by this technic.[4] Actually, such a high degree of sensitivity is rarely needed. When the transplacental hemorrhage is massive enough to cause anemia in the newborn, the fetal erythrocytes are easily found in the maternal blood.

Difficulty in distinguishing adult reticulocytes from the fetal erythrocytes is sometimes encountered. This difficulty is not important unless the mother has a high reticulocyte count. In such a case, one can interpret the test result with consideration of the maternal reticulocyte count or use a modified staining technic[4] which is more complicated but can distinguish the maternal reticulocytes from the fetal erythrocytes.

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To What Avail . . . If Freedom Fail

WHEN A professional man is treated like a professional man, he behaves like one. When he is treated in some other way, he reacts accordingly.*

Dr. Joseph J. Farber of the Belgian Medical Union addressed the Illinois Medical Society on May 17 and told how political considerations have altered the practice of medicine in Belgium and how such developments led to the doctors' strike.

Before World War II the practice of medicine was entirely free in Belgium, with public assistance for the poor. Medical insurance was mostly provided on a private basis by trade union mutual aid societies.

Social security became compulsory in 1945 and involved all workers. The mutual aid societies then began to reimburse workers for their medical expenses according to a certain fee schedule. In the industrialized regions and in the poorer parts of the country, the level of fees charged by private physicians gradually fell to the reimbursement level.

Due to the rapid rise in the standard of living and the low cost of medical care, the number of medical visits and the demand for medical care increased. Mutual aid insurance was not able to cover as much of the total medical cost as formerly and had to be supplemented by state contributions. This created a race between medical expenses and financial resources, with no end point in prospect.

The political parties attempted to solve the dilemma by advocating measures designed to provide a balance between quantity of medical care, quality of medical care and the amount of money provided by social security.

Belgian doctors in the past had been accustomed to caring for the poor and receiving nominal fees from them or from the

* Many American newspapers editorially castigated the Belgian medical profession for striking, while trying to preserve their special position of privilege and esteem. It seems that our editorialists failed to see that one can not reduce a professional man to a bureaucratic tool of the state, stripping him of his professional dignity, ethics and financial and social position; and at the same time expect this degraded individual to act with all the professional and moral virtue that one has hitherto associated with Medicine!—Reprinted from the *Medical Bulletin of Northern Virginia*, April, 1964.

government. Their income at a normal fee level from the well-to-do provided an income which allowed them to do charity work at small fees. When, however, social security placed all workers on the reimbursement schedule, all fees tended to deteriorate to an impossibly low level.

Under recently proposed legislation, doctors were invited to contract with insurance companies on a set fee schedule, the level of which was approximately one-third of normal fees. The law provided for "controlling doctors" at the rate of one per 40 practicing doctors, with regulations to limit medical care and medicine and with heavy fines and even jail terms for doctors not adhering to the regulations.

The law provided that if 60% of the physicians "signed up," the system would be in effect and the remaining physicians could practice in any way they chose. Those not signed up would automatically receive 25% less reimbursement than those of contracting doctors.

Discussions between the Belgian Medical Union, which represented 90% of the doctors and the government broke down and resulted in the "strike." Dr. Farber was responsible for the organization of emergency medical service in Brussels and assured his audience that a sufficient number of physicians and facilities were available and that no patient suffered as a result.

Negotiations have been held since the strike and eleven principles have been agreed to in order to remove the objectionable elements in the proposed law.

Dr. Farber lists three lessons which the Belgian physicians have learned:

First, the paramount importance of unity in the medical corps. There were differences of opinion between specialists, G. P.'s, town and country doctors. Their most important efforts have always been directed toward obtaining at any cost a unanimity of aims out of a conflict of purposes between colleagues. Ninety-seven percent of the doctors agreed to the strike.

Second, the importance of one single organization uniting the various tendencies within the medical corps. The 11,000 doctors were represented by only six spokesmen in negotiations with the government.

Third, in a democratic county, when the citizens' liberty is threatened by socialist tendencies, resolute action taken by a professional group, aided by modern public relations and information technics, can upset even the most elaborate conspiracies against freedom.

Guest Editorials

Cytology in Cervical Cancer: Note on Survey and Technic

THE MARCH, 1964 issue of *The Journal of the Florida Medical Association* carries a report on cytology in cervical cancer, a "three year Community Cancer Demonstration Project that covered 19 counties in Florida."

Four percent of the women examined showed "abnormal cytology (Pap III, IV or V) . . . cervical cancers proved by biopsy . . . numbered 199, for a rate of 19 per thousand women examined" (10,174). "Eighty percent . . . were in the in situ stage," and 20%, invasive. Women known to have had cancer were not included in the study.

An interesting, and important, "by-product" of the work showed one technic to be superior for screening purposes:

> "An outgrowth of the project showed cervical scrapes were superior to vaginal aspirations in finding cervical cancer. Drs. Samuel A. Gunn and W. A. D. Anderson, co-directors of the project's Central Cytology Laboratory, University of Miami, made a comparison of vaginal aspirations versus cervical scrapes from the first 89 women with positive tissue diagnosis of carcinoma of the cervix. Dr. Gunn reported that no vaginal aspirations were positive when the cervical scrapings were negative. He pointed out that of the 63 cases of carcinoma in situ confirmed, the vaginal aspiration picked up 21; of the 14 cases of invasive carcinomas, the vaginal aspiration picked up seven."
>
> * * * *
>
> "Numerous inquiries about this pro-

gram from other states prompted the production of a "pic-tape" which documented the steps involved in the planning and implementation of a cervical cytology program in a Florida county. The "pic-tape," a 35mm filmstrip with narration on tape, is available on loan, from the Division of Chronic Diseases, Florida State Board of Health."

As a corollary to this, mention should be made of recent promotions of "do-it-herself" technics. Some of these projects are even proposed on a mail-order basis, in order to get smears from as many women as possible. These schemes sound good but carry inherent defects, one of which is emphasized above, since the do-it-yourself kit usually employs the aspiration technic alone. In addition, by such programs and propaganda, women are not encouraged to have a real examination once a year, so that many would go for long periods of time without a check on other loci prone to cancer—notably the breasts and ovaries. Vulvar lesions might also be missed.

Even if symptoms were present, a report of "no cancer" based on a do-it-yourself aspiration would tend to give a false sense of security to that large segment of our population who have no true comprehension of these matters.

Thus it is just as important to make sure the *patient* understands the limitations of a mass screening project as it is for the doctor to understand it himself. The cytology smear is a test as valuable as any we have, yet it cannot supersede, or replace, a physical examination. Trite? Yes, but still a verity.—A. W. Cavins, M.D., Terre Haute.

An Insurance Yardstick for the Public

DO YOU KNOW enough about actuarial statistics to calculate a fair insurance premium? Probably not. And if you don't, the average layman doesn't either. The skilled insurance actuaries apparently do know. At least they manage, by the magic of their formulae, to keep American companies solvent and to keep insurance premiums within reach. But if the public doesn't understand how rates are calculated, they are bound to object to the increase of rates or the reduction of benefits.

In a free society, the survival of any institution rests upon its ability to satisfy the people it serves. When it fails to satisfy these wants, it gives way to something else. In the case of voluntary health insurance, that something will be compulsory government insurance. The American people know medicine's achievements; they want the benefits. Their desires, by virtue of advances in education and standards of living have been transformed into a demand. The demand must be met.

Modern medicine is costly by yesterday's standards. The average man cannot pay the bill out of pocket. We have become a nation of the middle class, accustomed to funding every major expenditure through installment plans.

In the light of this, there must be an effective financing device for enabling the average man to avail himself of the medical care his family wants and needs. So far, we have relied, in characteristic American fashion, on voluntary processes. We have looked to the nation's insurance carriers, its Blue Cross—Blue Shield plans and other private groups, to do the job. It is now charged that the voluntary processes are inadequate and must be supplemented by government intervention. Supplementation, in this context, means ultimate substitution.

Medicine and insurance, notwithstanding the preference of both to the contrary, influence one another. The kind and amount of the patient's insurance may determine whether he goes to the doctor at all. It may determine his choice of the doctor. Medical practice determines the kind, amount, and cost of insurance coverage written. Health insurance does not manufacture dollars. It distributes them.

Medicine and insurance share a common concern over the rising cost of medical care. Constructive consideration of the problem has been obscured by rate increase hearings, which brought forth loud and widely publicized outcries of abuse, mis-management and inefficiency. Accompanying these

charges were demands for vigorous policing of hospital care.

We must give the public a better understanding of the whys and wherefores of medical costs. In most things, the average man has some basis for comparison. He knows what he will have to pay for the things he wants. He can choose the expenditure that will bring him the most gratification, and can bargain with those who purvey it. None of this is true of medical care. Few people know what charges to expect. The patient cannot choose between medical care and something else. He cannot bargain. The insurance buying public is without satisfactory guides for determining the kind and amount of protection it needs, for judging the equity of either medical fees or insurance premiums.

When it comes to publicity, virtue runs a poor second to vice. So the evils and defects of insurance are well publicized. To get the other side of the picture before the public, a way must be found to instruct the layman in the ways in which rates are calculated and to show that insurance just doesn't manufacture new dollars. And it won't hurt some of us to refresh our understanding in this area, either.—Henry Davidson, M.D., Editor, P. O. Box 904, Trenton, N. J. Reprinted from *The Journal of the Medical Society of New Jersey,* March, 1964.

Editorial Notes . . .

The six-month trial of display of health literature in 360 pharmacies is completed. Thirty professional and voluntary health organizations contributed some five million pamphlets to the project. The object was to determine if pharmacies are logical locations for the distribution of health information of the type which can be placed in small public education pamphlets. The American Pharmaceutical Association and the Public Health Service cooperated in the study. All participating pharmacists and 1,200 patrons selected at random will now be interviewed.

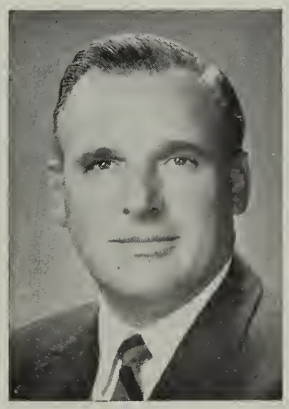
The columnist who signs himself as "Pertinax" in *The British Medical Journal* reports on complaints by physicians in regard to the National Health Service and quotes two doctors who complain of "completely unrestricted access to the general practitioner at any time of day or night for any trivial complaint that the patient thinks requires medical attention." The columnist's comment is that "These doctors, I am sure, would agree . . . with me that not all patients, or even most of them, behave like this—at least not all the time. But I have heard the same complaint from too many doctors during the past 15 years to doubt that this happens, and that it is a deterrent to good practice. It is obviously impossible to examine patients carefully when there is a crowd waiting for certificates and a bottle of medicine. The idea that the free-for-all, open-door policy will make it possible to diagnose disease at an early stage just doesn't hold water."

Dr. Wallace Buchanan, South Bend, Chairman of the Board of Chancellors of the American College of Radiology comments in the college bulletin regarding the investigation of the high cost of medical care by Senator Philip A. Hart, chairman of the Senate Antitrust and Monopoly Committee. The Senator is quoted as mentioning the possibility of monopolistic practices in pathology and radiology. Dr. Buchanan reminds us all that the charges did not originate with Senator Hart. It has been made by hospital spokesmen and by some government agencies. The college's continuing drive to define radiology as medical practice and not hospital service takes on added significance and importance with this new development.

Children, gasoline and gas water heaters should never be in the same room together. Four utility room fires resulting from the above combination are reported in the *JAMA* by Dr. Blalock of New Orleans. A little spilled or evaporated gasoline in a closed room with a flame is a dangerous parlay. Much better to store gasoline outside the house whether you have children or not. ◄

President's Page

Thoughts at random . . . thoughts while driving . . . mulling things over . . . Snow-bound at home for 24 hours for the first time since being in practice . . . Hard to believe with such a beautiful spring . . . My it is hot now! . . . My periodicals are piling up . . . Almost 100 doctors were delegates to the two political parties' state conventions . . . "A conservative Democrat" . . . "A moderate Republican" . . . in Indiana? . . . Will Rogers said, "I don't belong to any organized political party — I'm a Democrat!" . . . Hope the new dean of the I.U. medical school will be young — an academician — and, if possible, an I.U. graduate . . . Dr. Annis did his usual good job on Alumni Day. Strawberry Shortcake . . . Reminded a starry-eyed college girl with her first summer job in a mental hospital that the whole man must be considered — that the general practitioner is also a mighty important doctor . . . Per diem costs for in-hospital care by 1972 — $75.00 per day — *free medicine?* . . . Just received notice that college tuitions increase again next fall . . . Ike's magnificent documentary on D-Day . . . Off to the AMA . . . Glad to be in San Francisco again.



Contribute to I-HOPE. **Contribute to AMPAC.**

Donald E. Hood

The Woman's Auxiliary

REPORTS TO ISMA

This is the beginning of a new auxiliary year. As there is continuity in our programs, our thoughts revert to the events at the House of Delegates in Terre Haute. There were 165 registered and it was a delightful and worthwhile meeting. The enthusiastic reports of our state officers, state chairmen and county presidents caused us to be justly proud of our accomplishments in Indiana. Our guest speakers were Joseph R. Mallory, M.D., AMA Speakers Bureau, Dr. Don E. Wood, President, Indiana State Medical Association and Mrs. C. Rodney Stoltz, President, Woman's Auxiliary to the American Medical Association.



Mrs. Edward L. Rigley, our historian, has invited us to inspect our auxiliary records in the library of the new building of the Indiana State Medical Association. There are 22 bound volumes covering the years from 1942-1963, with one covering the early years from 1927 through 1941. There are three bound volumes containing every issue of the Hoosier Doctor's Wife.

We now have a new Bulletin of the Woman's Auxiliary to the American Medical Association which reveals medicine's current problems and goals and also contains human interest stories. It is enjoyable, educational and is designed for every member. When a county auxiliary has a project that is especially effective, it is suggested that a report be sent to the office of the American Medical Association, 535 North Dearborn Street, to be used in the Bulletin or in the AMA News.

Our state program chairman, Mrs. A. Alan Fischer, is busy with her committee compiling our Program Book which will be sent to each county president and president-elect and is used as a guide for county officers and chairmen in planning their auxiliary year. It is also a handy reference book for state officers and chairmen. The other two members of the program committee are Mrs. Robert S. Forbes and Mrs. H. Edwin Campbell, Jr.

Current events necessitate emphasis NOW in the field of legislation. Auxiliary members are ready to cooperate with their county medical society with "Operation Hometown." When the people at the local level understand, they're on our side. There is a ten minute colored film for the doctor's wife portraying how she, in only five minutes of her day, can help elect the candidate of her choice. This film is called, "Operation Dial" or "You, Too, Can Be the Life of the Party". There is a twenty minute film available for doctors and their wives called "The Opinion Maker" which portrays how the doctor, in an average day, can encourage people to work for candidates.

We are now anticipating the convention of the Woman's Auxiliary to the American Medical Association to be held at the St. Francis Hotel in San Francisco. This is a four day session and always provides new ideas and inspiration for the auxiliary year ahead.

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Gastroenteritis | Functional diarrhea | Drug-induced diarrhea | Postsurgical diarrhea

Lomotil controls the basic physiologic dysfunction in diarrhea—excessive propulsive motility. Pharmacologic evidence indicates that it does so by directly inhibiting propulsive movements of the intestines. This direct, well-localized activity controls diarrheas of widely varied origin and does so promptly, conveniently and economically.

The relatively few conditions in which Lomotil has given less than satisfactory control have been, for the most part, those such as severe ulcerative colitis in which too little anatomic or functional capacity of the intestines remains for the motility-lowering action of Lomotil to have effect.

It should be noted, however, that Lomotil has proved highly useful in mild to moderate ulcerative colitis and in several other refractory forms of diarrhea.

The recommended initial adult dosage is two tablets (2.5 mg. each) three or four times daily, reduced to meet the requirements of each patient as soon as the diarrhea is controlled. Maintenance dosage may be as low as two tablets daily. *Children's* daily dosage (in divided doses) varies from 3 mg. for a child of 3 to 6 months to 10 mg. for one 8 to 12 years of age. Lomotil is an exempt narcotic; its abuse liability is low and comparable to that of codeine. Recommended dosages should not be exceeded. Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia. Lomotil should be used with caution in patients with inpaired liver function and in patients taking addicting drugs or barbiturates. Lomotil is a brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of atropine is added to discourage deliberate overdosage.

Research in the Service of Medicine **SEARLE**

Practicing Medicine in Rural Indiana: Theme of Program for Future Physicians

INDIANA PHYSICIANS, practicing medicine in rural areas of the state, told junior and senior medical students of their experiences April 11 at the Sheraton-Lincoln Hotel in Indianapolis.

The Junior-Senior Day program, an annual affair sponsored by the Indiana State Medical Association's Commission on Public Health, is designed to encourage future doctors to consider rural practices. Dr. Emmett B. Lamb chairs this commission.

Drs. Dan L. Urschel, Mentone; Forrest Babb, Stockwell and Eugene S. Rifner, Van Buren discussed their practices and appeared on a panel to answer questions. Doctor Rifner was chairman of the commission's sub-committee which arranged the afternoon and evening affair.

On hand, too, were students' wives and fiancees who had an opportunity to learn of the pleasures and problems of the country doctor's wife. Approximately 300 attended.

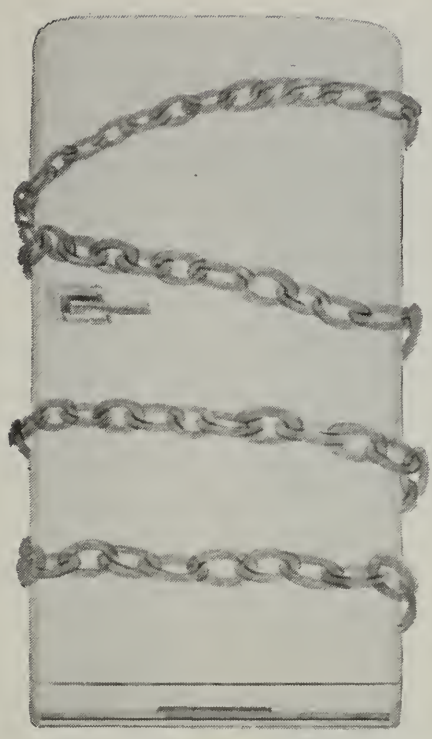
Other participants were Dr. Joe Black, president-elect, Indiana State Medical Association; Dr. Lamb; Mr. Frank Woolley, field representative, American Medical Association, banquet speaker and Rev. John A. Whitesel, Indiana University Medical Center Chaplain.

Others were Dr. Glen V. Ryan, Indianapolis, president of Mutual Medical Insurance Inc., and Richard B. Holmes, Mead Johnson Laboratories.

The afternoon sessions were followed by a social hour, sponsored by Mead Johnson, and the banquet sponsored by Blue Shield.◄



AMONG PARTICIPANTS and planners for the annual Junior-Senior Day April 11 in Indianapolis were (left to right) Rev. John A. Whitesel, Indiana University Medical Center Chaplain; Emmett B. Lamb, M.D., chairman of the ISMA's Commission on Public Health, sponsoring group; Dr. Joe Black, president-elect; Dr. Eugene Rifner, program chairman for the annual event; Dr. Glen V. Ryan, president of Mutual Medical Insurance, Inc., and Richard B. Holmes, representative of Mead Johnson Laboratories.



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Description: Each scored tablet contains 5 mg. 'Methedrine' brand Methamphetamine Hydrochloride.

Dosage: 2.5 mg. (½ tablet) 3 times daily. May be increased gradually according to response; more than 10 mg. daily rarely is needed. The last dose of the day should not be taken later than 6 hours before bedtime.

Side effects: Insomnia may occur if taken later than 6 hours before retiring. The usual peripheral actions of sympathomimetic amines (vasoconstriction and acceleration of the heart) are minimal and little noticed on low or moderate dosage.

Contraindications and precautions: Should not be used in patients with myocardial degeneration, coronary disease, marked hypertension, hyperthyroidism, insomnia or a sensitivity to ephedrine-like drugs. Moderate hypertension in the obese is not necessarily a contraindication since it may be relieved as the overweight is reduced.

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The second of three articles on medical staffs, hospital committees and medical records.

Robert's Rules of Unparliamentary Procedure

II. The Treatment of Pharmacoplethora

IAN ROSE ("Robert Rose"), M.B., B.S.
Kamloops, British Columbia

THE STUDY of methods for the manipulation of hospital medical staffs is continued in this consideration of the problems facing specific committees.* In this paper the pharmacy committee is examined and the therapy of pharmacoplethora, the syndrome which it is their duty to treat, is described.

While members of a hospital medical staff are always ready to restrict each other's medical practice by a progressive narrowing of the fields of the specialist and general practitioner, they are generally reluctant to limit the therapeutic freedom of the individual. This is most apparent in the plethora of esoteric preparations demanded from the pharmacy. From time to time the pharmacy committee will have to present a list of obscure and unproved drugs that it wishes to drop from stock and others which it considers desirable to restrict to selected cases. In doing so, it is essential for the pharmacy committee to understand the law of diminishing resistance. This may be stated as follows:

"The staff resistance to the curtailment of drugs is in inverse proportion to the number of items on the list and directly proportional to the square root of the time since the last detailing by a pharmaceutical house of the individual item."

This law may be expressed as: $R=\frac{\sqrt{x}}{y}$ where R is the resistance of the medical staff; y the number of items on the list; and x the average time-interval since the detailing of the various products.

Clearly, the calculation of x presents many problems, and in order to avoid the necessity for the repeated determination of this value the following procedure is recommended:

Such lists are to be presented at infrequent intervals and made as long as possible. It is essential that the time taken in reading the list exceed the psychological boredom limit of 4.5 minutes.* Two or three special items should be included in the list. These should consist of common drugs, but in a form in which they have never been produced and certainly never stocked in the pharmacy. Examples of these forms are intravenous cascara or rectal carbolic acid.

When this list has been read slowly, its acceptance should be moved and seconded by the committee chairman and a member, respectively. Objection will almost inevitably be raised to one or two of the planted hypothetical items. The committee chairman should give a show of argument for a few minutes and then gracefully withdraw his objection and agree to delete the mythical product from the list. The general discussion and the conciliatory action of the committee will have satisfied the staff vanity so that the rest of the list may be passed without any further discussion.

It is interesting to note that John Felty Gunderson, the original creator of this procedure and author of a number of invaluable papers relating to medical staff management, including the now-famous "The Psychological Basis of Governmentoplegia," used the same non-existent product in this procedure for 12 years before it was

* *JISMA*, May, 1964, pp. 452-456.

allowed to pass out of the supposed stocks of the pharmacy.

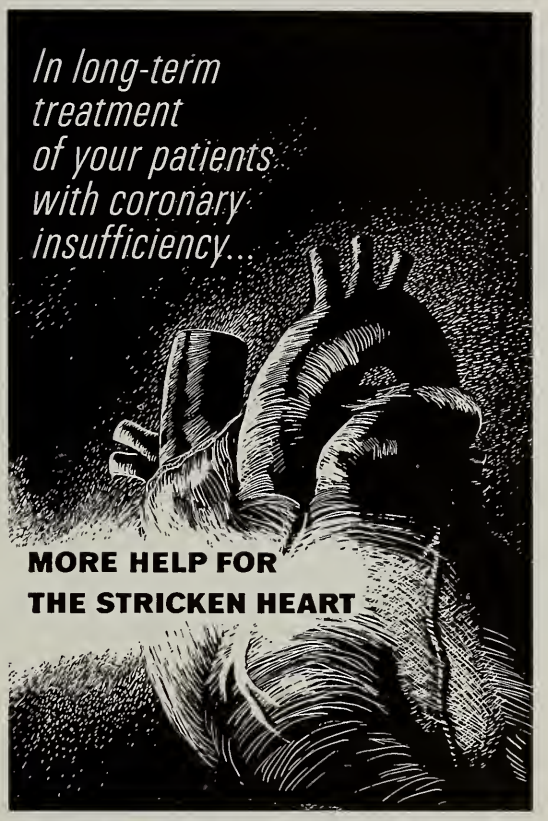
Our surveys indicate that the methods adopted in the attempted treatment of pharmacoplethora are many and various. Judging by the growing size of pharmacy stocks in the hospitals studied, we believed that there was some urgency in the publication of this paper and the wider dissemination of an understanding of the law of diminishing resistance. For this reason we decided to give precedence to this consideration of the pharmacy over other committees; subsequent papers will deal with the specific problems of the latter.— Reprinted from the *Canad. Med. Assn. J.* 89:27, 1963. ◄

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Civil Defense Emergency Hospital — Plans and Training for Maximum Utility*

PAUL S. PARRINO, M.D., M.P.H.†
Washington, D. C.

PLANS FOR UTILIZING the Civil Defense Emergency Hospital (CDEH) are based on the objectives of the emergency health services program—which are to provide medical care for the sick and injured of the surviving population following an attack.

With the advent of thermonuclear weapons, it became necessary to change the emphasis of the medical care program which originally was predominantly a casualty care program that could become operational almost immediately and would be in operation only a relatively short period of time. The supplies and equipment for the original CDEH were based on this concept. Our present planning anticipates the need for medical care well beyond the first few days following a nuclear disaster.

In order to support our present program, it was necessary to add items to the CDEH which would increase its capabilities from primarily a traumatic surgical hospital to one which could provide medical care to all types of serious sickness and injury; the change in our concept is appropriately reflected in the 1962 CDEH. It contains sufficient expendable supplies to be operational for a 30-day period after which back-up supplies would be available and the CDEH could remain operational as a general medical-surgical hospital for a year or longer.

The CDEHs previously procured and prepositioned will be brought up to the level of the 1962 unit. This will be done by supplementing the original units with the necessary items and increasing their operational capability based on expendables from 72 hours to 30 days.

The Pharmacy Section is one of the largest areas reflecting this expansion content-wise. The 1962 CDEH contains 98 pharmaceutical items which include 60-odd therapeutic categories based on the United States Pharmacopoeia classification.

Preparedness Is Many Plans

A well-equipped CDEH is important, but that is only one step towards preparedness. Plans to utilize the CDEH must be a part of every community's emergency health services plan. Also, there must be plans for staffing this hospital based on available health manpower resources.

The CDEH is intended primarily:

1. To permit the establishment of a 200-bed general medical and surgical hospital in an existing structure, such as a school building, warehouse, or church; or
2. to provide the supply and equipment basis for the expansion of a permanent hospital.

If the actual post-disaster situation does not require that the CDEH be used for one of the above purposes, it can very readily be utilized for expedient purposes, in accordance with actual post-disaster needs, after other community resources, such as supplies in department stores, pharmacies, etc. have been exhausted. Thus, it may serve to supply first-aid teams, first-aid stations, or emergency treatment stations, or it may be used as a source of back-up supplies for all community medical care activities.

At best, it is an educated guess as to what the disaster situation will be in any community or area. Therefore, it is necessary that health services have alternate plans to

* Presented to the 14th National County Medical Societies Conference on Disaster Medical Care, Chicago, Illinois, November 2, 1963.

† Chief, Research Branch, Division of Health Mobilization, Office of the Surgeon General, Public Health Service, Department of Health, Education and Welfare.



FIGURE 1
A COMPLETE 200-bed Civil Defense Emergency Hospital as it looks crated and in storage. (Office of Civil and Defense Mobilization photograph.)

care for the sick and injured according to the exigencies of the disaster situation. No *one* medical care plan will meet all situations.

What types of training programs should be developed utilizing the CDEH? First, let me say that training in basic professional content should not be attempted. This is taught in medical schools. Instead a familiarization or orientation to austere medical care is necessary. Austere medical care is medical care that must be practiced in various disaster situations where supplies, equipment, personnel, physical facilities and utilities are limited or not available.

Training of allied health workers also follows this broad principle but falls into two categories:

1. Expanding existing functions of the allied health or medical discipline—to meet the austere situation where automation will not exist and improvisation will be required; where there will be early discharge of patients and those occupying a hospital bed will be critically ill, requiring intensive care insofar as possible in an austere situation; where the health needs of the surviving population will increase enormously due to disruption of water supplies, sewage disposal treatment facilities, increase in insect and rodent population and a general deterioration of environmental sanitation which will increase the prevalence of sickness; where there will be less direct medical supervision; where there will be many trained and untrained volunteers giving service and care, thus requiring greater supervision — to mention a few.
2. Additional functions are those not normally practiced by the allied health or medical worker. They include medical functions prescribed and delegated by medical authority and based on the "need to know." This is determined at the community level, according to the community's plan for personnel utilization and assignment in the post-attack period.

Professional personnel need to become familiar with the CDEH—and this is a form of training. They need to know the type and kind of supplies and equipment in the CDEH

and how to use or operate the equipment with which they are not familiar, e.g., 40-quart pressure cooker sterilizer, the hand-operated Wangensteen apparatus, to mention only a few. Personnel should know their CDEH assignment and how it relates to the overall staffing pattern and lines of authority. Some assignments would require specific training, such as personnel assigned to the x-ray section, laboratory and central supply.

Training Unit Improved

Up to the present time, 100 complete CDEHs were available for training purposes. These, unlike the pre-positioned units, could be opened and used in whole or part for training exercises. Seldom were the 200 cots used in setting up the training unit. Also, to transport the CDEH from place to place for various types of training proved to be costly. Besides, how many cots does one have to see to know what a cot looks like? The same can be said about surgical instruments, dressings, bedpans, blankets and the like—to say nothing about the loss of items.

Recently, the CDEH training unit has had an improvement. With consultation from various sources, the Division of Health Mobilization developed a prototype Emergency Hospital Training Unit. It is a compact, manageable unit containing 20 cots and generally, one of each item in the CDEH. The training unit when set up contains the following sections:

Admitting and Triage
Ward
Operating Room
Central Supply
Laboratory
X-ray
Pharmacy
Maintenance

The items such as instruments and supplies are in a special packaging of polyethylene skin board and are on display in the appropriate section. These prototype training hospitals will be located at selected sites for field testing. The degree to which they measure up or fail to accomplish the objectives of serving as useful training hospitals will be evaluated. Changes and modifications will be made in anticipation of procurement of additional training units. Right now, we have 12 prototype training units assembled. Eight have been sent to states for testing and evaluation, two are in the depot awaiting shipment to states, one will be kept at headquarters in Washington and one is on exhibit at this AMA sponsored meeting.

To further help with CDEH preparedness, manuals are being developed as training tools. Just about off the press are the following: "Establishing the Civil Defense Emergency Hospital" and "Checklist for Developing a CDEH Utilization Plan." A few more are at the printer's and should be available soon. Still others are in the final stages of preparation.

Training is a never-ending process and CDEH training is no exception. We have made some progress; we still have further to go—but with your help, we can keep moving. ◄

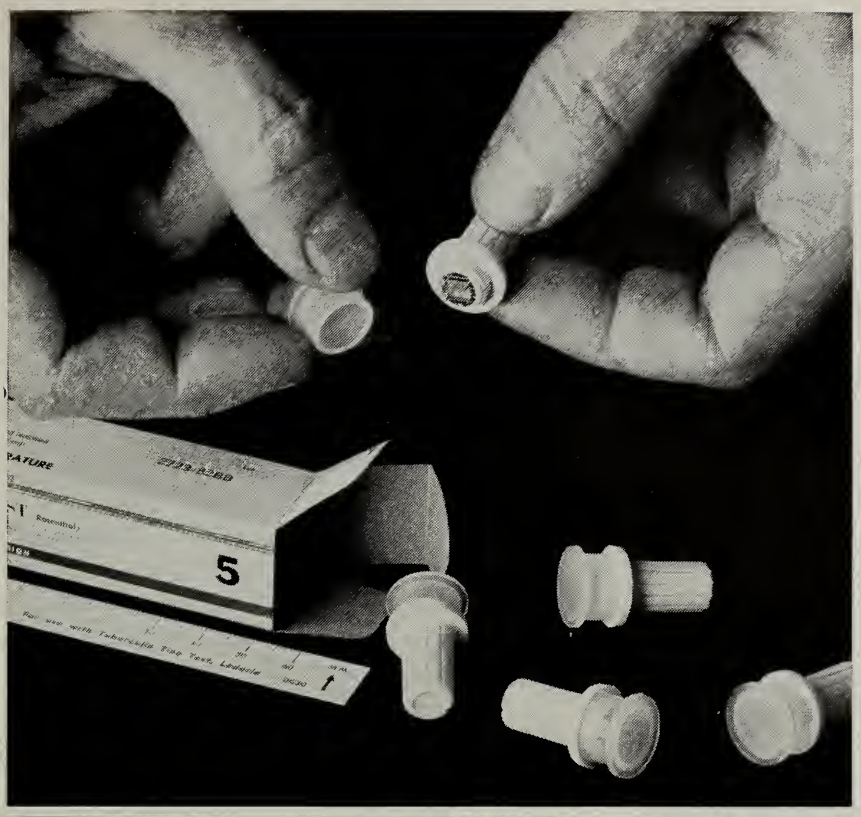
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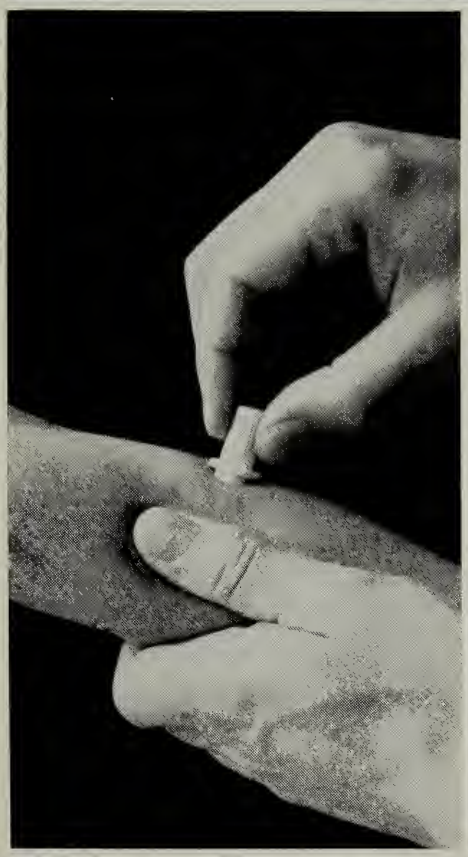
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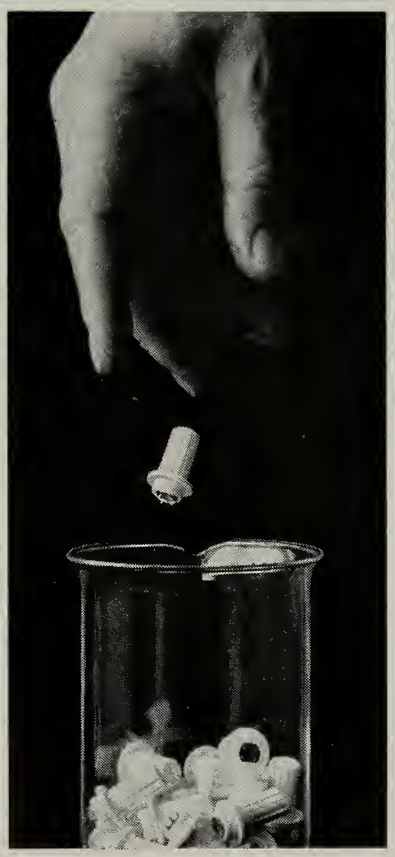


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Medical Panorama

D.O. Situation—California and Florida

A. W. CAVINS, M.D.
Terre Haute

An account based on an editorial in *California Medicine* was published in our *Journal* in May, 1963 (Vol. 56, No. 5, p. 584.) This account concerned the California unification of medicine and osteopathy. It was noted that "There remain several problems to be solved before all differences are completely removed in California. Such questions as compound society membership and specialty certification are still to be answered."

Further explanation of the present status of this problem has been received from the Executive Director of the California Medical Association, as follows, from a letter dated January 22, 1964:

"The unification agreement entered into in 1961 between the California Medical Association and the California Osteopathic Association has been fully completed. Unification is now a fact. There remain a few post-unification steps to be accomplished, chiefly two, which are:

"1. Temporarily the former California Osteopathic Association became the Forty-First Medical Society and is chartered as a component society of the California Medical Association. In time it is intended to dissolve the Forty-First Medical Society but not until absorption of its members into our county medical societies has been substantially accomplished. No one can prophesy the period of time that will be required to complete this process. Several years probably will be necessary.

"2. The specialty status of a few of the former osteopaths and particularly a few individuals who were in residency training at the time of the unification, still remains unsolved. Efforts to reach a fair and equitable solution are under way."

In the meantime, the July, 1963 issue of the *Journal of the Florida Medical Association* carried an editorial on this subject showing an approach, or point of view, from a different angle, written by a member of the Board of Governors of the Florida Medical Association. Excerpts follow:

> "The Board of Governors declared that the practice of cultism is not a matter of degree and any osteopath who adheres to the original tenet of osteopathy is a cultist. It recognized that many, licensed as osteopaths, have veered away from its basic concept and are practicing a dilute type of medicine. It recommended that studies be made whereby those individuals, licensed as osteopaths, who desire to be recognized as practitioners of scientific medicine, can pursue courses of study and training through the facilities of medical schools and postgraduate medical education to obtain a degree of Doctor of Medicine, entitling them to be recognized by other doctors of medicine as professional colleagues. At present, there appears to be no demand in the state for these facilities, and the Board thought that until such a time does exist the door should be kept open and such proposals welcomed without the Association initiating any steps in this direction.
>
> "The House of Delegates of the American Medical Association recognized that problems pertaining to osteopathy are peculiar to the several states and recommended a declaration of principles at state levels. In like manner, the Board of Governors realizes different problems are present in the same state at county levels, depending upon the physician concentration, the availability of medical and hospital care, the quality of and economics involved in this care and the varying management and staff organizations of hospitals. For this reason, it was thought

that no broad policy, covering all situations in the state, could be made at this time and it was recommended that component county societies of the Association establish policies regarding relationship of doctors of medicine with osteopaths within their own area. Complaints or problems which cannot be solved at local levels should be submitted through appropriate committees to the Association for consideration and action.

"It was further stated by the Board that since the right to practice a healing art in a hospital is generally controlled and granted by boards composed of lay members, it shall not be considered an unethical act per se for a member of this Association to practice in a hospital required by law or its rules and regulations to admit cultists to practice, provided he does not enter into any professional relationship with them.

* * * *

"Since the medical profession is dedicated to the best quality of medical care for all people, the Board had no option but to declare that until the present over-all situation throughout the state changes, our attitude withholding professional recognition of osteopaths as a group must be maintained. At the same time, this member of the Board had a definite impression that the wish to extend a helping hand to those who sincerely desire to spend the time and effort to qualify for the degree of Doctor of Medicine was genuine and void of any sense of arrogance. The degree of Doctor of Medicine does not confer upon the recipient the right to stagnate. Medicine must be a continuing program of education for its members who are doctors in fact as well as name. If many of them do not consider the sacrifice too great to give up one or more years of practice for additional hospital or postgraduate training to improve their professional stature, is it not reasonable to expect osteopaths to do as much if they desire professional equality?"

It is our impression that the last three sentences of this extract echo the sentiments of many Indiana physicians and that the outline of principles given in the second and third paragraphs is close to the present policy of the Indiana State Medical Association. Howbeit, we do await with interest the further experience of our California brethren. ◄

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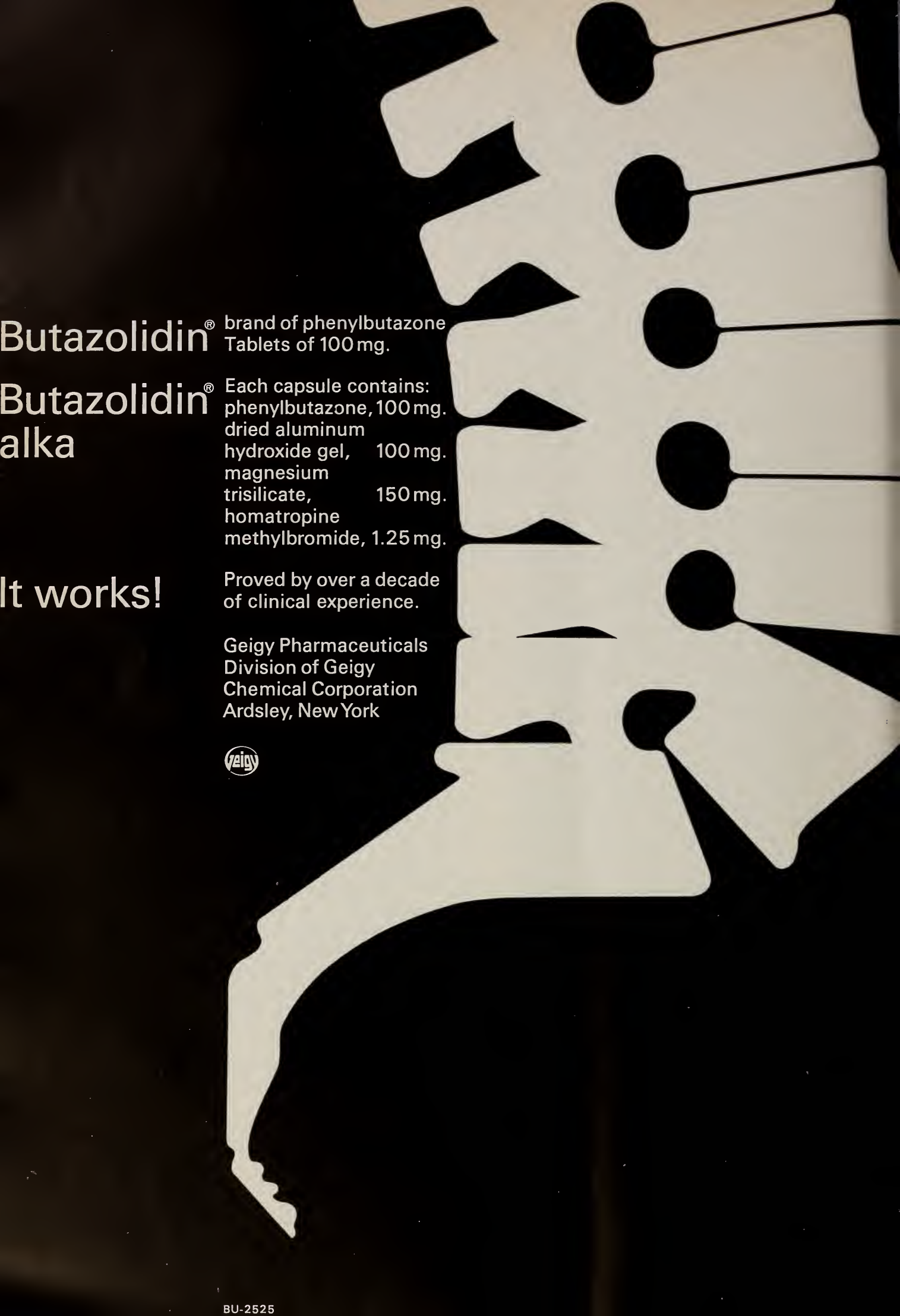
SUBJECT: Unauthorized Signatures on Official Opium Order Forms (Form No. 2513)

Examinations of the triplicate copies of official opium order forms reveal that many of these forms are signed by unauthorized persons. Section 151.165 (a) and (b) of Narcotic Regulations No. 5 states, in part, that the official narcotic order forms shall be signed by the purchasing registrant in the same form as on the application for registration (Form No. 678) or may be signed by another person authorized by power of attorney (Form 1315) previously filed with and approved by the District Director of Internal Revenue. Under no circumstances should other persons sign these forms.

We find that most of these violations occur at the retail level. Certainly pharmacists are well aware of the responsibilities associated with the purchasing of narcotic drugs. The order forms are intended solely to cover dispositions of taxable narcotic drugs and preparations to registered persons. Part of the system for controlling narcotics is dependent on these order forms. Therefore all registrants are cautioned to avoid violating the regulations by properly executing these official order forms.

George H. Gaffney
Acting Commissioner of Narcotics

April 14, 1964



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Medicine At Law

DECISIONS AND OPINIONS

Highlights of recent court actions pertaining to health and medicine from *The Citation* prepared by the Law Division of AMA.

Doctor Cannot, Through Cross-examination, Be Made Patient's Expert Witness—A patient was not allowed to use a doctor as an expert witness to prove his own professional negligence. The patient was not entitled to recover damages from the doctor in a malpractice action based on the allegedly negligent performance of a bilateral femoral arteriogram, an Ohio intermediate appellate court ruled.

Following the performance of the bilateral femoral arteriogram by the doctor, the patient suffered necrosis of his skin and underlying tissues which necessitated skin graft operations.

In presenting the patient's case, his attorney called the doctor for cross-examination under the adverse witness statute. He asked the doctor some questions which required expert testimony. The trial court sustained objections to such questions and the doctor, therefore, gave no expert testimony. No expert witness testified on the patient's behalf.

A patient may not establish his case in chief by the expert opinion testimony of the doctor by calling him for cross-examination under the adverse witness statute. If the patient wanted the doctor's expert opinion testimony, he should have called him as his own witness, the court ruled.

On the basis of the facts presented, negligence on the part of the doctor was not so obvious as to be within a layman's comprehension and, in order for the case to have been submitted to the jury, the patient had to present expert testimony showing negligence on the doctor's part, the court said. The patient presented no such testimony. Therefore, the direction of a verdict for the doctor was proper, the court held.

Oleksiw v. Weidener, 195 N.E. 2d 813 (Ohio, Jan. 23, 1964).

Sale of Professional Business with its Good Will Does Not Imply Promise Not to Compete—An optometrist who sold his business to another optometrist for $25,000 was free to set up another office and go into business in competition with the buyer. The written contract provided that sale included the good will of the business, as well as equipment, stock of goods and other assets. However, the contract did not contain a covenant not to compete, and the court held that no such covenant could be implied.

The buyer contended that the seller had told him that he wanted to retire from business, and that that was the inducement for the sale. The court refused to admit evidence of any such oral agreement, since the written contract specified the consideration for the sale.

The buyer claimed that the seller's return to practice had deprived him of business, since many of the seller's former patients, who had become the buyer's patients following the sale, returned to the seller when he set up his new office. The court ruled that the seller could lawfully deal with former patients who elected to patronize him, since he had a right to enter into a business in competition with the buyer.

Joseph v. Hopkins, 158 So. 2d 660 (Ala., July 18, 1963).

Pennsylvania "Captain of the Ship" Doctrine Applied in Federal Court—Under the Pennsylvania "captain of the ship" doc-

Continued

Continued

trine, an anesthesiologist would not be liable but a surgeon would be liable for any negligence in or adjacent to the operating room by a head technician of a blood bank where the negligence resulted in the transfusion of a patient with incompatible blood. A majority of the U.S. Court of Appeals for the Third Circuit so ruled.

The patient, Israel Abrams, was hospitalized for gallbladder surgery to be performed the following day. He was placed in room 807. The same day another patient of the same name was admitted and placed in Room 342. The anesthesiologist directed the blood bank to set aside two bottles of blood for the Abrams on whom surgery was to be performed the following day. The blood bank's head technician, after checking the hospital census, directed the I-V team to take a specimen of the blood of the Abrams in Room 342. That blood was type "A." Apparently, the head technician discovered that afternoon that there were two Israel Abrams in the hospital and took a blood sample from the Abrams in Room 807. That Abrams' blood was type "O, Rh-positive."

During the operation the next morning on the Abrams from Room 807, his cystic artery was severed, making a transfusion imperative. The anesthesiologist then discovered that the bottle of blood which had been placed in the operating room was labeled "Israel Abrams" but that the operating room chart showed the bottle was marked "342 A Positive." He summoned the head technician to the operating room and talked to him, at or through the door, which was only a few feet away from the surgeon. The technician said that the room number was a clerical error and that it would be proper to give the blood to the patient. One pint of the blood was given to him. The blood was not of the proper type and the patient suffered a transfusion reaction. The patient died several days later. There was substantial evidence that the administration of the incompatible blood was the cause of death.

The trial court instructed the jury that neither the surgeon or the anesthesiologist could be held liable for the negligence of any employee of the hospital. This instruction was erroneous as to the possible liability of the surgeon for any negligence on the part of the head technician of the blood bank and, although no proper exception was taken to the instruction, the error was so plain as to require a new trial, the court ruled.

During the course of an operation, the surgeon is, under the law of Pennsylvania, in the same complete charge of those who are present and assisting him as is the captain of a ship over all on board. Since the surgeon has this complete charge over all those present and assisting him, he is responsible for any negligence on their part. When the head technician came to the operating room door, he came under the surgeon's control, the court said. It was the head technician's assurance that the blood was proper that caused the transfusion, an integral and essential part of the operative procedure, to be proceeded with. If the head

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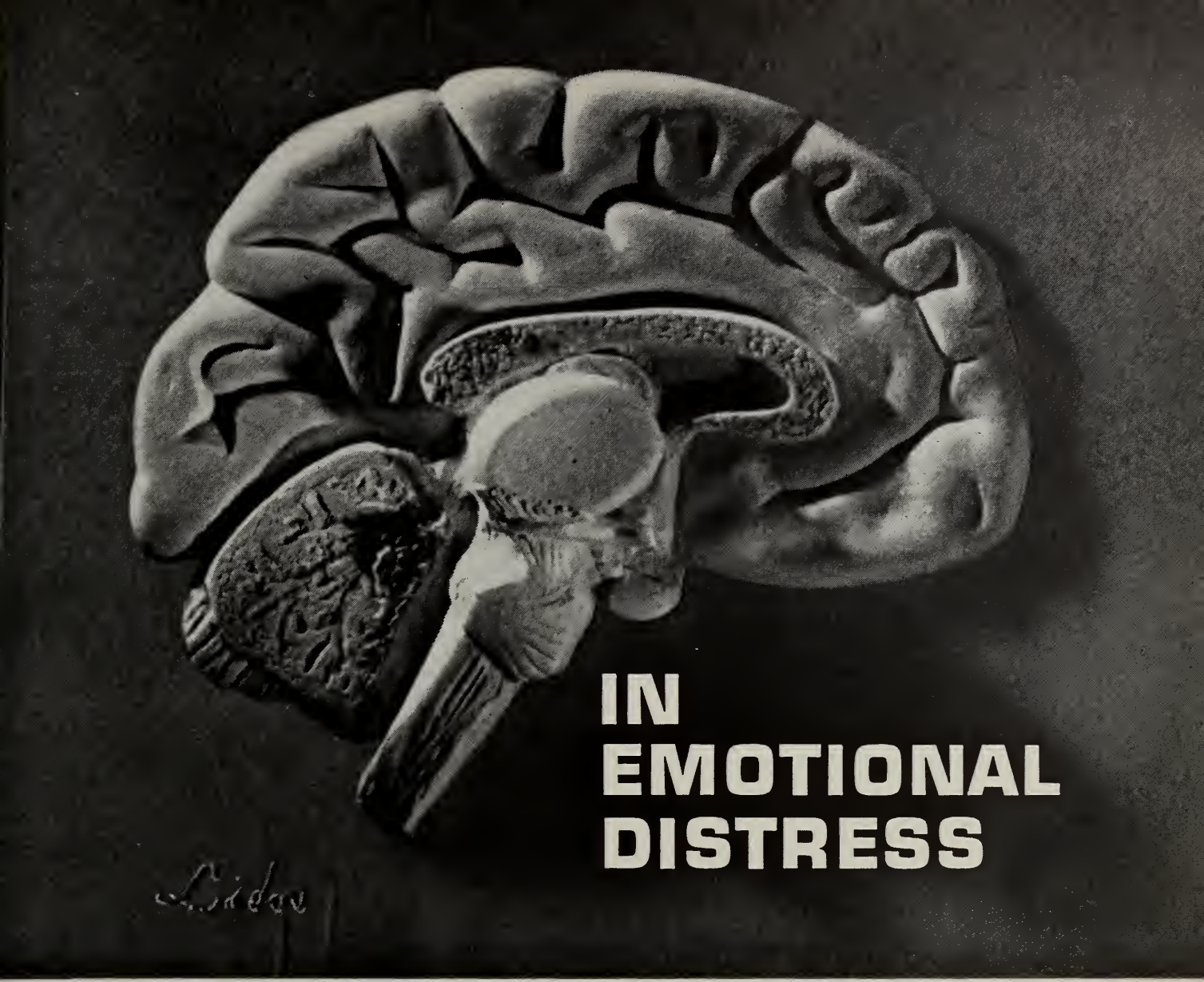
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Continued

technician was negligent in giving that assurance, the surgeon would be liable for that negligence, the court ruled.

There was no evidence of any individual negligence on the anesthesiologist's part. The anesthesiologist could not be held liable for any negligence on the part of the head technician because he was not the "captain of the ship," the court ruled. To say that because the anesthesiologist was in charge of the transfusion, he was responsible for any negligence on the part of the head technician would extend the ship's captain doctrine too far beyond the present bounds of the law of Pennsylvania. It would greatly distort that law to say that it was plain error to fail to instruct a jury that there can be two captains of the ship at one and the same time, the court said.

One judge dissented with respect to the ruling that the anesthesiologist could not be held liable for any negligence on the part of the head technician.

Mazer v. Lipschutz, 327 F. 2d 42 (C.A. 3, Dec. 30, 1963).

Hospital not Liable for Fall Over TV Cord—A jury returned a verdict of not guilty in favor of the hospital on a claim by a patient that she fractured her left wrist when she fell over the cord of a rented television set. A patient had been hospitalized for treatment of phlebitis in her leg. She claimed that the cord ran across the floor to the socket at the foot of her bed. The hospital denied this and also showed that the patient's doctor had authorized bathroom privileges without any assistance from nurses.

Quincer v. Highland Hospital, Cir. Ct. of Boone Co., Docket No. 16059 (Ill., Sept. 26, 1963). ◄

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Art, Hobby Show Planned For ISMA Indianapolis Meeting

Space will be provided at the 1964 annual meeting of the Indiana State Medi cal Association, Oct. 13-15 at Indianapolis, for a Physicians Art and Hobby Show.

Members of ISMA interested in exhibiting pieces and requiring any information regarding this can contact any one of the following:

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108 W. 7th Street
Bloomington

Dr. Charles P. Schneider
2211 W. Franklin St.
Evansville 12

Dr. Truman E. Caylor
303 S. Main St.
Bluffton

Dr. Frank H. Coble
51 S. Eighth Street
Richmond

Dr. Lall G. Montgomery
Ball Memorial Hospital
Muncie

ISMA Headquarters
3935 N. Meridian
Indianapolis 8

It will be the responsibility of each physician to see that his work gets to the exhibition at the Murat Temple. Final arrangements will be taken care of by Dr. Holland and his committee.

The ISMA will provide suitable display facilities, but each physician is responsible for transportation costs and any other such expense involved in entering his exhibit.

Application for Space in Art and Hobby Show Exhibit

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108 W. 7th Street
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The Physician's Role in Promoting Blue Shield Growth and Development (1)

(One of a series prepared by Blue Cross-Blue Shield)

(The following article is based on excerpts from the presentation made by Daniel F. Hanley, M.D., Executive Director of the Maine Medical Association, at the 1964 *Indiana Blue Shield Seminar. It has been edited somewhat for use as a two-part article in this magazine. The second article will be published next month.)*

In preparation for this talk, I asked doctors, Blue Shield administrators and hospital administrators this question: What are the real responsibilities of physicians toward Blue Shield, and what can we do about Blue Shield's growth and development? I was surprised to find that the notes I made from these several conversations were very similar and could be grouped around four particular points. It is on this grouping that I would like to base this section of my paper.

On the first point, the answer was unanimous; simply that physicians should know what they are talking about. Laymen and physicians should know what insurance is, what it does and what it can and cannot do.

The second point mentioned but this only by the hospital people and the administrators of the plans, was that physicians should take more interest in the program. They should "talk it up." They should become active in encouraging patients to join and to correctly utilize their insurance.

The third point stressed by the administrators of the plans was that physicians should stop griping about the minutiae of the program. I was shown a pile of correspondence with one physician who does about $12,000 business a year with his Blue Shield plan, and this correspondence was over a question of a $50 service which was not covered in the contract. I am certain if that gentleman were dealing with any other company with which he did that volume of business during a year, the disagreement would have been settled very easily. But, unhappily, we tend to look upon Blue Shield, or for that matter all insurance, as a sort of vague, faceless entity which is somehow out to engulf us, and which must be beaten, gripped and controlled or else it will smother us.

Some physicians seem to exhibit a distinct paranoia when talk of insurance programs and voluntary prepayment programs comes up. Perhaps this is because we are all a product of our times. We were raised in an era when pre-payment insurance was looked upon with suspicion by medical groups, by insurance companies or by the public at large.

With this brief rundown on these three points, I would like to remind you that while my interviews were for the most part informal, I believe they are of some value, because they were the actual responses of people who have worked, and who are working, in the medical care field.

The role of the physician in the growth and development of Blue Shield is closely linked to his understanding of the principles upon which insurance is based. The physician has to know about health insurance himself before he can use it correctly, or before he can tell his patients how to use it.

Health insurance is a medical tool. It is an effective means of paying the health care expenses of large numbers of people. But it is the only piece of medical equipment that the patient tells the physician when and how to use. The patient pays for his office calls, and his medicines, and his physiotherapy, and everything else, but doesn't tell the physician when and how to use them. The patient may purchase bandages, or crutches, or plaster, but the physician tells him when to use them and, equally important, the physician tells the patient when to stop using them.

You all know about the principles of insurance, but have you explained them to those with whom you come in contact? In order for insurance to operate effectively

and efficiently, the company must be able to calculate the risk. The insured person must not benefit from the loss. This is the problem of multiple coverage.

These are all straightforward principles, and they work as long as we cooperate and do not try to abuse them. However, in utilizing this tool in covering large groups of people, must the patient participate in the loss either via services not covered or via a deductible, or via a co-insurance feature, or any combination of these?

It is very important for us to realize and to communicate to those carrying voluntary health insurance that a dollar from the health insurance budget will purchase just so much service. Insurance is not a means of stretching dollars. It is a technic for conserving dollars, for shepherding them for their most effective use.

Now health insurance varies somewhat from other insurance. In life insurance, it is easy. The policyholder is either dead or alive, and you pay or you don't pay. Endowments are easy for insurance companies. The policyholder has reached a specified age for his endowment or not. But health and accident insurance is to be used when the patient is ill, and "thereby hangs the difference."

Doctors either do not know the importance of the effective use of health insurance, or they simply don't care. The effective delivery of health services where and when the people need these services is one of the greatest challenges of our time. Many thousands of people will live longer and more productive lives if we can more widely apply the great wealth of medical knowledge available to us. ◄

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Psychiatry October 21 & 28, 1964 (at Crawfordsville)
Psychiatry November 4 & 5, 1964
Basic Electrocardiography . . . November 11, 12 & 13, 1964
Pediatrics December 9, 1964
Urology December 10, 1964
Dermatology January 27 & 28, 1965
Orthopedics February 10, 1965
Treatment of Emergency Conditions (Provisional) February 11, 1965
Psychiatry February 18 & 25, 1965 (at Muncie)
Obstetrics & Gynecology March 3 & 4, 1965
Anatomical & Clinical Otolaryngology . . . March 22-April 3, 1965
Ophthalmology March 24, 1965
Management of Congenital Defects (Provisional) March 25, 1965
Advances in Gastroenterology April 7, 1965
Advances in Cardiology April 8 & 9, 1965
Radiology April 6-10, 1965
Psychiatry April 21 & 28, 1965 (at Fort Wayne)
Psychiatry May 19 & 26, 1965 (at Hanover)

ABSTRACTS

BOOK REVIEWS

LYSOSOMES

Ciba Foundation Symposium, Little, Brown & Co., Boston, 1963. Edited by A.V.S. de Reuck and M. Cameron; 446 pages with numerous figures and tables; $11.50.

Lyso*zyme* is in the dictionary; lyso*some* is too recent to have attained this distinction: Nevertheless, this symposium discusses just this particular bag of acid hydrolases: the most recent discovery of the immense complexity making up the cell cytoplasm. To be more precise: we might think of them as subcellular structures bounded by a unit membrane and containing not only acid but also neutral hydrolases. These enzymes aid uniquely both in *endo-* and *exo-* cytosis; the better known process of *pinocytosis* may be just one of the manifestations of a most complex process.

The newer methods of examination have opened up vistas undreamed of even a generation ago. At present, we are still in the stage of giving new names to processes being perceived but dimly. The atomic physicists were most happy when they discovered the electron, proton and neutron. Then came all the various waves and particles that were to bewilder the poor students. Lysosomes (to me) appear to be a manifestation of a similar stage in the study of the cell, its components and details of its functions.

This monograph is for the expert, analyzing critically the work of his peers. The careful general reader will not get an intelligible picture until still newer findings bring everything into clearer focus. The present monograph is strictly an interim dated effort.

ARNOLD LIEBERMAN, M.D.
New York, N. Y.

RENAL BIOPSY: CLINICAL AND PATHOLOGICAL SIGNIFICANCE

Ciba Foundation Symposium, Little, Brown and Co., Boston, 1962. Edited by G. Wolstenholme and M. Cameron, 395 pages, numerous figures, tables and illustrations, $10.50.

The first renal biopsy was reported by Professor Brun just as the 1950's were opening. Now there are many medical centers with experience running well into the hundreds. Professor Brun participated in this symposium at which a collective experience of over 5,000 percutaneous renal biopsies was analyzed.

The indications, counterindications, pre-biopsy work-up, technics, post-biopsy care and complications are discussed in helpful detail. The agreement on some phases of approach as well as the disagreements are well brought out. I liked particularly the meticulous presentation of the tech-

Recent reports suggest...insulin and sulfonylureas may accelerate lipogenesis,[1-5]...serum "insulin" levels are often elevated in obese diabetics[2,3,6]...DBI (phenformin HCl) reduces high blood sugars, lowers elevated "insulin" levels, tends to reduce body weight toward normal.[1,3,7-9]

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In the obese diabetic (ketoacidosis-resistant), DBI (phenformin HCl) with a proper diet: **A.** acts to reduce high blood sugar without increasing fat synthesis or weight gain. **B.** does not increase already elevated endogenous insulin levels; may, indeed, act to restore more normal levels. **C.** favors reduction of weight.

In the ketoacidosis-resistant obese diabetic not amenable to diet alone, hypoglycemic DBI (phenformin HCl) appears to help avoid weight gain or reduce adiposity, factors which otherwise tend to make blood sugar control more difficult and to increase the likelihood of complications. However, in the ketoacidosis-prone diabetic, insulin is still the essential hypoglycemic agent.

Summary: Indicated in stable adult diabetes, sulfonylurea failures and unstable diabetes. Gastrointestinal side effects occurring more often at higher dosage levels abate promptly upon dosage reduction or temporary withdrawal. Occasionally an insulin-dependent patient will show "starvation" ketosis (acetonuria without hyperglycemia) which must be differentiated from "insulin-lack" ketosis, and treated accordingly. Use with caution in severe liver disease. Not recommended without insulin in acute complications (acidosis, coma, infections, gangrene, surgery). Consult product brochure for full information.

Bibliography: 1. Williams, R. H.: Textbook of Endocrinology, Ed. 3, Saunders, Philadelphia, 1962, p. 610. 2. Gordon, E. S.: Metabolism 11:819, 1962. 3. Grodsky, G. M. et al.: Metabolism 12:278, 1963. 4. Sadow, H. S.: Metabolism 12:333, 1963. 5. West, K. M. and Tophoj, E.: Metabolism 10:689, 1961. 6. Yalow, R. S. and Berson, S. A.: Diabetes 9:254, 1960. 7. Weller, C. et al.: Scientific Exhibit, A.M.A., June 1962. 8. Weller, C. et al.: Metabolism 11:1134, 1962. 9. Radding, R. S. et al.: Metabolism 11:404, 1962.

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nics that are becoming standard procedures.

The microphotographs are works of art; the tables and illustrations are very enlightening; the format, printing and binding are up to the highest standards.

All in all, this gives the reader a superb analysis of an addition to our diagnostic armamentarium. Early diagnosis and unequivocal knowledge of the exact *LIVING* pathology is aided immeasurably by this relatively harmless and apparently simple procedure. The report of this symposium deserves the careful attention of ALL internists, general practitioners and students of the subject of renal disease.

ARNOLD LIEBERMAN, M.D.
New York, N. Y.

Abstracts From Various Literature, Prepared by AMA

EXTERNAL CARDIAC MASSAGE FOR CARDIAC ARREST DUE TO MYOCARDIAL INFARCTION

W. F. Minogue (153 W. 11th St., New York), A. A. Smessart, W. J. Grace, *Amer. J. Cardiol* 13:25 (Jan.) 1964

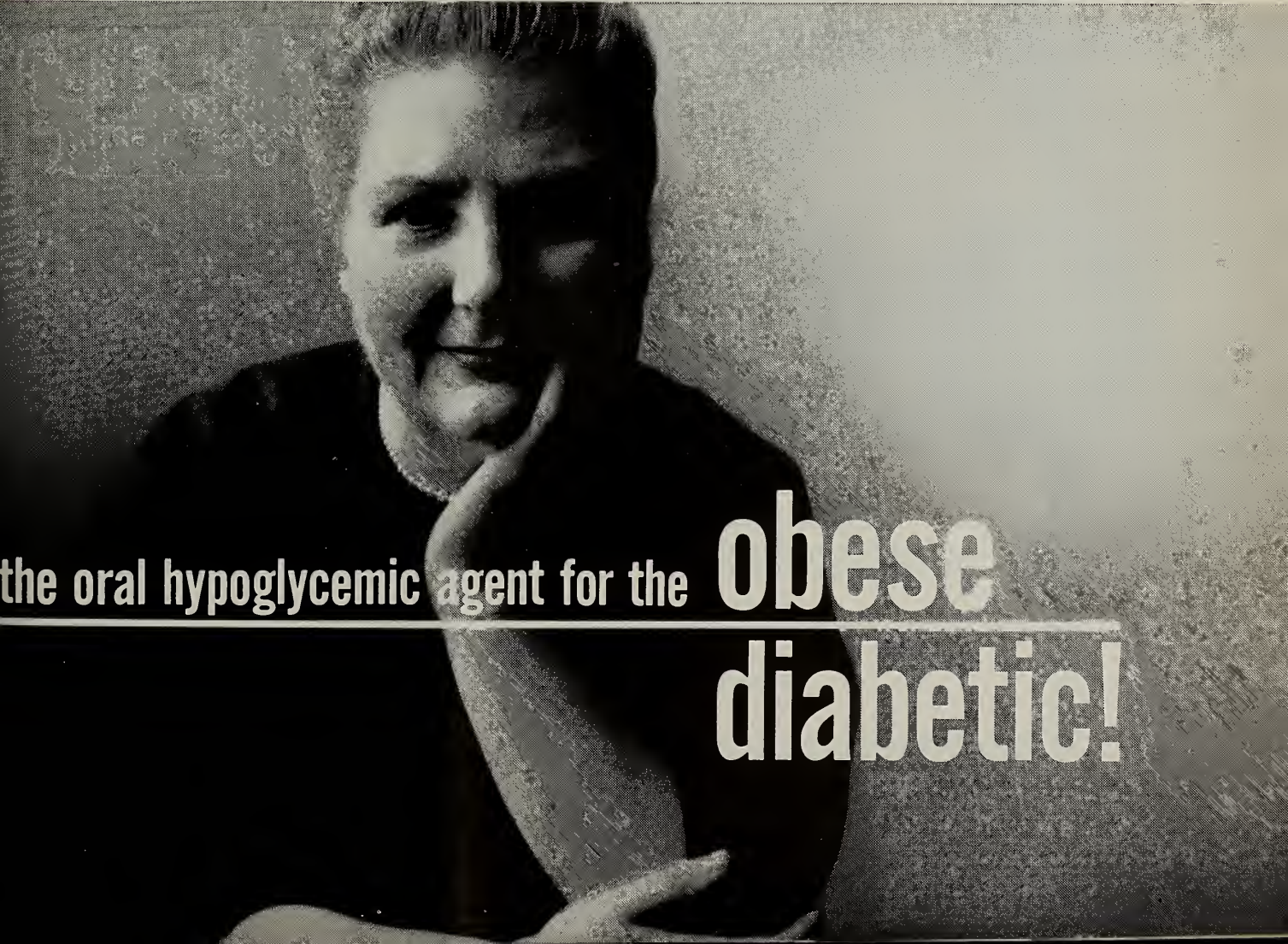
A vigorous approach to cardiac resuscitation has been made possible by the simplicity and effectiveness of external cardiac massage and external defibrillation. This is accomplished by a specialized emergency team who provides an open airway, maintenance of cardiac output by external cardiac massage, use of appropriate drugs for arrhythmias and hypotension and external defibrillation by counter shock and external pacemaker stimulation. The author's team attempted these methods on 60 patients with acute myocardial infarction; 29 patients were successfully resuscitated and 12 recovered completely. In only one long term survivor did near-fatal arrhythmia develop when no physician was present, but a couple of nurses managed to keep the patient with external cardiac massage and mouth to mouth breathing until the team arrived. In addition to early detection, the authors wish to emphasize the necessity of sustained, energetic application of the method. For example, most patients with ventricular fibrillation required two or more shocks and one survivor had 26 minutes of cardiac massage and seven precordial shocks.

AVULSION OF THE GALLBLADDER

E. Halkier (Copenhagen County Hospital, Gentofte, Denmark), *Danish Med. Bull.* 10:262 (Dec.) 1963

The author presents the histories of two men, aged 33 and 44 respectively, who sustained severe abdominal trauma as the result of motor vehicle accidents. They also had multiple lesions of the extremities and of thoracic organs. At laparotomy

Continued



Continued

in both patients, an otherwise normal gallbladder was found completely torn away from its liver bed, and hanging by its cystic duct. The cystic artery was torn. Both livers showed minor ruptures, but not in the vicinity of the gallbladder. Some abnormality of the liver was found in both patients; one had cirrhotic changes and the other showed fatty degeneration. The avulsion of the gallbladder was treated by cholecystectomy. Both patients died as the result of their other injuries from two to five days after the operation. The prognosis seems to be dependent on the accompanying lesions.

PERSONALITY DIFFERENCES BETWEEN SMOKERS AND NONSMOKERS

E. J. Salber (1 Shattuck St., Boston), J. E. Rochman, *Arch. Environ. Health.* 8:459 (March) 1964

Three hundred four senior students attending a public high school were given a group psychological test, the Minnesota Counseling Inventory, in an attempt to measure personality differences between those who smoked, had stopped smoking, or who did not smoke. Boys who smoked and girls who smoked heavily had less satisfactory relationships with authority in general, and parents in particular, than did nonsmokers. Item analysis of the inventory shows marked differences in response to questions by sex and by the smoking category of student. A very important social drive in this age group is the need for status or prestige. Children who are less well adjusted in the field of family relations and adult authority are more likely to seek security in the company of their peers and to use a cigarette, which at one and the same time symbolizes adulthood, superiority and defiance.

SMALL-BOWEL NEOPLASMS: ELUSIVE SOURCE OF ABDOMINAL SYMPTOMS

G. O. Strauch (593 Eddy St., Providence, R. I.), *Surgery.* 55:240 (Feb.) 1964.

The surgical records and autopsy findings of 78 patients with primary small-bowel neoplasm are analyzed in an attempt to define the diagnostic problems presented by such neoplasms and to suggest methods of treatment. Malignant lesions were present in 74.4% of 43 symptomatic cases. The symptoms included nausea and vomiting, abdominal pain, abdominal tenderness, intestinal obstruction, palpable mass and intestinal hemorrhage. The diagnosis was established preoperatively in 53% of symptomatic cases by x-ray examination. Most of the failures in diagnosis occurred because a possibility of small bowel tumor was never considered in the differential diagnosis. In a few cases, laparotomy is the only diagnostic recourse; it is justified when the patient's case has been properly evaluated and roentgenograms have been unrevealing, but suspicion exists. ◄

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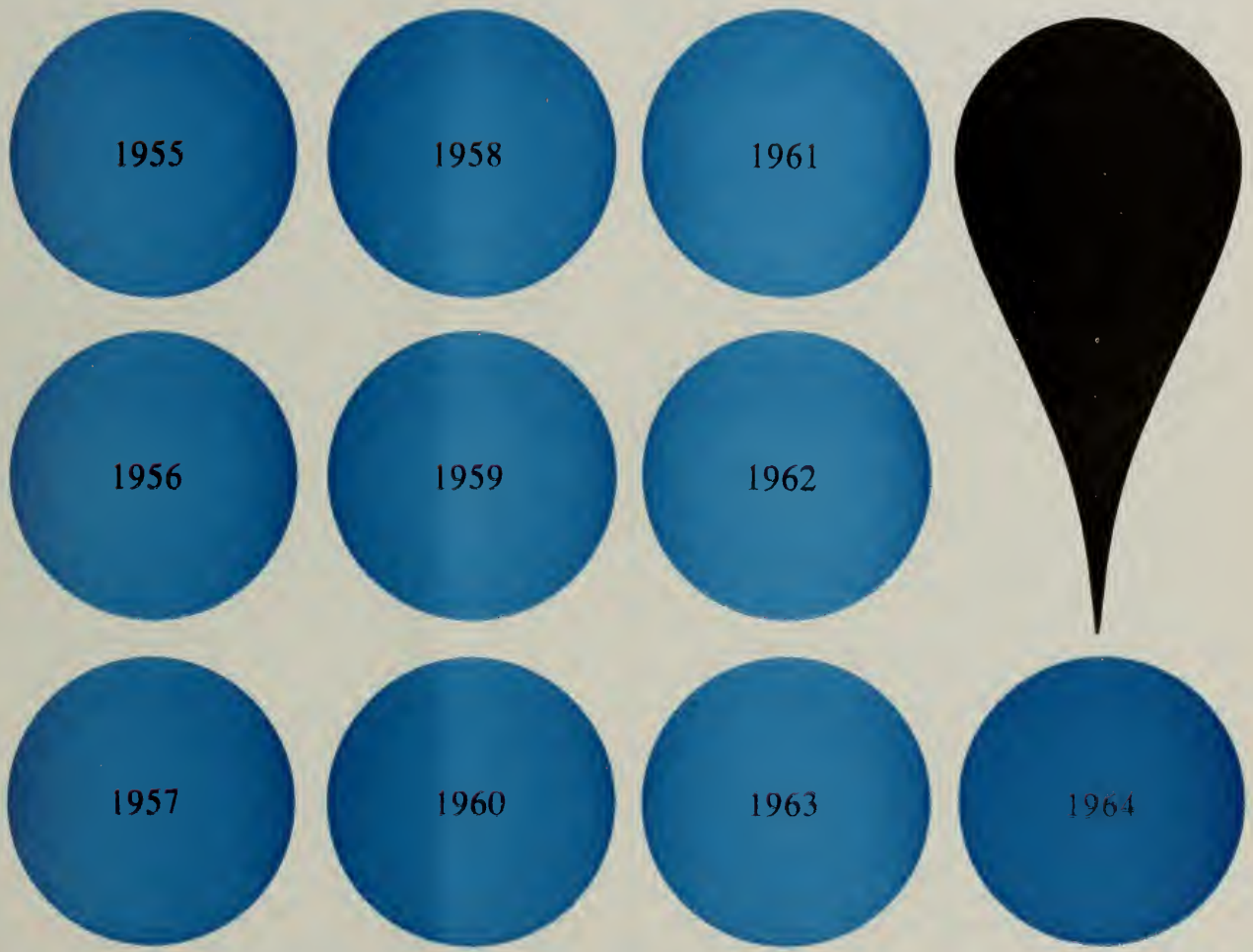
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Paul H. Duffey, 5857-B Demoret Ave., Fort Knox, Ky.—*Internal Medicine*

Dean H. Diment, 620 N. E. 29th St., Oklahoma City, Okla.—*Ob-Gyn*

Boris W. Kreel, 318-B Bataan Rd., Fort Lee, Va.—*Ob-Gyn*

David Lewis Spalding, 2201 E. 39th St., North, Kansas City, Mo.—*Ophthalmology*

Joseph T. Kaye, 4109 Walnut St., Philadelphia, Pa.—*Orthopedics*

Franklin E. McCoy, Spreekelsville, Maui, Hawaii—*Pathology*

Thomas F. Plaut, 514 E. 88th St., New York, N. Y.—*Pediatrics*

William R. Chambers, 8674 Cottonwood Dr., Cincinnati, Ohio—*Psychiatry and Neurology*

Wilford D. Hoofer, 2127 W. Norfolk Rd., Portsmouth, Va.—*General Surgery*

Roland B. Mernitz, Jr., 443 Carnation, Imperial Beach, Calif.—*General Surgery*

Paul D. Mabie, University of Texas Hospital, Galveston, Texas—*Plastic Surgery*

David E. Cowan, 1393 Tara Rd., Charleston, S. C.—*Urology*

K. H. Kim, 401 E. 74th St., Apt. 3H, New York, N. Y. 10021—*Physical Medicine and Rehabilitation*

ADDITIONAL LOCATIONS

Floyd County—GEORGETOWN—population 700, with a post office serving about 4,200. Large area without the services of a physician. New modern office building available. Located close to New Albany where hospital facilities are available. For further information contact Mr. Sylvan Roy or Miss Hazel A. Kirk, Georgetown, Indiana.

Lake County—GARY—Wanted—general practitioner—orthopedic surgeon—ophthalmologist to join 19 man clinic. New clinic building with complete x-ray and laboratory facilities. Two excellent open staff hospitals. Unusual opportunity to work into full partnership in short period of time. No investment necessary. Contact Edward Adomaitis, The Gary Clinic, 6111 Harrison St., Gary, Indiana, for further information.

Wayne County—RICHMOND—population close to 40,000. Located on U. S. 40. Need for two general practitioners, a pediatrician, dermatologist and ear, nose and throat physician. Hospital facilities available. Earlham College located in Richmond. Contact Charles V. Sage, M.D., 48 S. 11th St., Richmond, Indiana, for details. ◄

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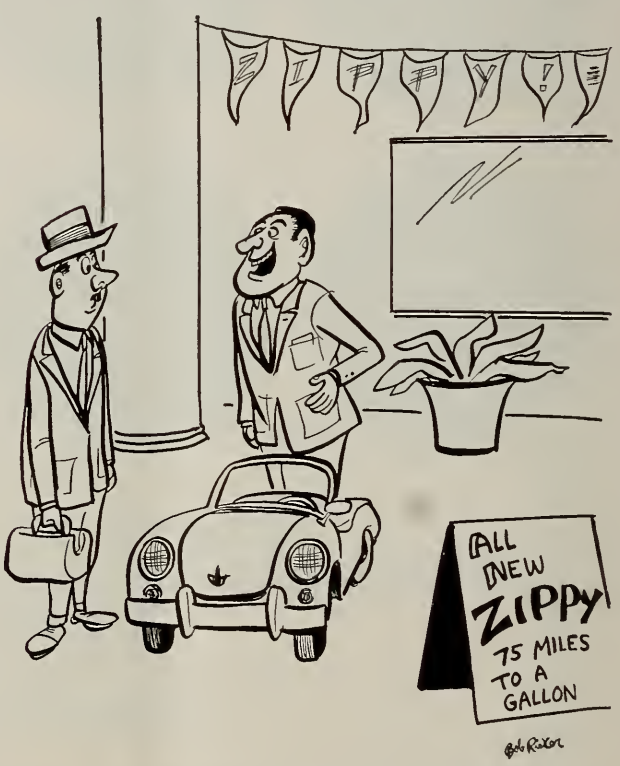
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The Journal Welcomes New ISMA Members

R. C. Anderson, M.D., *Psychiatry,* Indiana University, 1929. (Wayne-Union)

Bryant A. Bloss, M.D., *Orthopedic Surgery,* University of Louisville, 1958. (Vanderburgh)

Edwin R. Carnes, M.D., *Anesthesiology,* Vanderbilt Medical School, 1956. (Clark)

Robert E. Hales, M.D., *General Practice,* Indiana University, 1960. (Montgomery)

Kingsley Lawrance, M.D., *Surgery,* St. Bartholomew's Medical School, London, 1946. (Marion)

L. L. McCallister, M.D., *General Practice,* Indiana University, 1959. (Delaware-Blackford)

Felix Millan, M.D., *Physical Medicine and Rehabilitation,* National U. Medical School of Mexico, 1954. (Marion)

William J. Moran, M.D., *Ob-Gyn,* Indiana University, 1958. (Marion)

Howard Pierson, M.D., *Obstetrics,* Jefferson Medical College, 1944. (Lake)

Forest F. Radcliff, M.D., *Orthopedic Surgery,* University of Louisville, 1953. (Vanderburgh)

Warren Ricchetti, M.D., *Pathology,* University of Oklahoma, 1960. (Tippecanoe)

Wendell A. Riggs, M.D., *Pediatrics,* Indiana University, 1958. (Tippecanoe)

Thomas G. Samter, M.D., *Pathology,* Indiana University, 1952. (Marion)

Richard L. Schultheis, M.D., *General Practice,* Indiana University, 1960. (Owen-Monroe)

Thomas Speer, M.D., *Industrial Medicine,* University of Pittsburgh, 1955. (Lake)

A. J. Venables, M.D., *Pathology,* University of Alberta, Canada, 1943. (Vanderburgh)

David N. Vigor, M.D., *Industrial Medicine,* Wayne State University, 1953. (Marion)

Richard L. Westerman, M.D., *Industrial Medicine,* Wayne State University, 1952. (Vanderburgh)

Russell E. Wigh, M.D., *Radiology,* Harvard Medical School, 1939. (Bartholomew-Brown)

Stanley M. Zydlo, M.D., *General Practice,* Stritch School of Medicine, 1960. (Wabash) ◄

SCIENTIFIC EXHIBIT APPLICATION FORM

Committee on Scientific Exhibits
Indiana State Medical Association
3935 N. Meridian Street
Indianapolis 8, Indiana

Please send me an application form for a Scientific Exhibit at the ISMA Annual Convention, October 13-15, 1964, Murat Temple, Indianapolis, Indiana.

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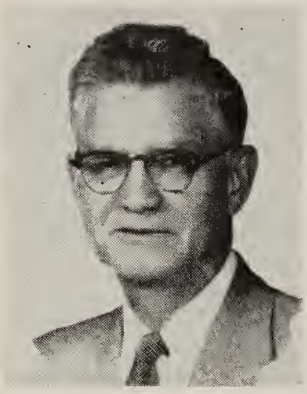
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Dr. Eli S. Jones Named Winner of Highest Industrial Medicine Award

Eli S. Jones, M.D., of Hammond, has been accorded the highest honor in the field of industrial medicine. The Industrial Medical Association conferred upon him the William S. Knudsen Award at the annual banquet of the Association's 49th annual meeting in April in Pittsburgh, Pa. A bronze plaque, symbol of the honor, is awarded each year to a physician who has made an outstanding contribution to industrial medicine. The presentation to Dr. Jones was made by Lemuel C. McGee, M.D., Medical Director of the Hercules Powder Company, Wilmington, Del.



Dr. Jones, who was cited for a long list of activities and accomplishments in the field of industrial medicine, is a member of the House of Delegates of the American Medical Association and has been a member of the AMA's Council on Occupational Health since 1956. He was elected its chairman last January. His staunch championship of industrial medical activities was credited with bringing about a greater understanding of the field of industrial medicine among many circles within the AMA. His work in establishing industrial medical committees within his county medical society, as well as at the state level, was recognized as being extremely instrumental in the intelligent interpretation of compensation laws in the county and state.

Among the many offices held by Dr. Jones, he was president of the Industrial Medical Association, 1956-57; president of the Central States Society of Industrial Medicine and Surgery, 1958-59; and chairman of the Occupational Health Institute from 1957 to 1961. He is also a former president of the Lake County (Ind.) Medical Society, a board member of the Indiana Blue Shield, a member of the Lake County Board of Health, and for 16 years was chairman of the Indiana State Medical Association's Industrial Health Committee.

Dr. Jones is senior member of the Jones Clinic in Hammond, and a member of the staff of St. Margaret Hospital, also in Hammond. He received his medical degree from Indiana University in 1916. He is a Fellow of the American College of Surgeons, the International College of Surgeons, the American College of Preventive Medicine and the International Academy of Proctology. He is a diplomate of the American Board of Preventive Medicine, certified in occupational medicine.

Dr. Doan Appointed Director

Richard L. Doan, Ph.D., a native of Lapel, and a graduate of Indiana University with an AB and an AM in physics, has been appointed director of the Atomic Energy Commission's Division of Reactor Licensing. Dr. Doan retired in 1963 as manager of the Atomic Energy Division of Phillips Petroleum Company.

Treatise on Industrial Medicine Now Available to Physicians

A comprehensive guide on industrial medical service has been published by the Occupational Health Institute. The author is Dr. J. S. Felton of the University of California at Los Angeles.

The 80-page treatise is designed to be of practical value to part-time, as well as full-time industrial physicians and surgeons. It may be obtained by sending 40 cents to the Institute at 55 E. Washington St., Chicago 60602.

Dr. Ginsberg Wins Award

Dr. Stewart T. Ginsberg, Indiana Commissioner of Mental Health, received an Award of Merit at the recent annual meeting of the Tri-State Hospital Assembly. The award recognizes persons responsible for progress in hospital care.

Indiana Physicians Are Preceptors In SAMA-Sears Scholarships

Ten outstanding medical students will spend two months with a practicing rural physician as a result of the renewal of the SAMA-Sears Preceptor-Scholarships. This is a national program but this year it is concerned with two Indiana physicians as preceptors.

John F. Selden, a senior at University of Michigan Medical School, has been with Dr. Roger S.

Continued



THE PHYSICIANS of Gary have been awarded the top trophy for having exceeded their United Fund quota by the largest amount. The doctors raised nearly twice the amount assigned to them for the campaign. Pictured with the trophy are: Robert Burbie, Public Relations Director for Sears Roebuck Company, toastmaster at the dinner; John B. Twyman, Executive Secretary of the Lake County Medical Society, General Campaign Chairman; W. K. Robinson, M.D., Chairman of the Physicians Division and George Hrnjak of the United Steel Workers Association, chairman of the Planning Committee for the affair.—**Gary Post-Tribune photograph.**

Roof of Spencer, Indiana from April 1 to May 30.

Kenneth C. Johnson, a junior at Northwestern University Medical School will be with Dr. Jack Bland of Holland, Indiana from October 1 to November 30.

Dr. Unger Wins Lilly Award

Roger H. Unger, M.D., chief of the metabolic section of the Veterans Administration hospital at Dallas, Texas, has been named winner of the eighth Lilly award, given by the Eli Lilly Company for research in diabetes.

Dr. Unger will receive the award—which consists of a medal, $1,000 and an invitation to present his paper on diabetes—July 23 at the banquet of the Fifth Congress of the International Diabetes Federation in Toronto.

Since November, 1955, his research work has significantly increased the knowledge of diabetes in the discovery of a vital enzyme, which functions in relation to the level of blood sugar.

New York Legislature Makes PKU Tests Mandatory

The New York State Legislature has passed a bill requiring that every newborn infant in the state be given a blood test for phenylketonuria (developed by Robert Guthrie, M.D., of Buffalo.)

Under the New York measure, physicians and heads of institutions caring for infants up to the age of 28 days are responsible for making sure that the PKU test is given as prescribed by the state health commissioner.

Massachusetts is the only other state where the phenylketonuria test is mandatory.

Indiana Doctors Named Fellows Of American Ob-Gyn College

The American College of Obstetricians and Gynecologists inducted seven Indiana physicians as Fellows at the annual meeting in Bal Harbour, Florida.

Dr. Myrle F. March of Fort Wayne, Dr. Roger V. Solis of Hammond, Drs. James E. Carter, J. M. Maas and Neil R. Strickland of Indianapolis, Dr. Charles R. Mather of Lafayette and Dr. Charles Abell, Jr., of Marion are the new Fellows.

"Safe Handling of Radioactive Materials" Handbook is Available

"Safe Handling of Radioactive Materials", a handbook of the National Bureau of Standards may be obtained for 40 cents by writing to the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C., 20402.

The book covers control of radiation exposure; instruction and supervision of personnel; physical safeguards; procedural safeguards; radiation instrumentation; transportation of radioactive materials and disposal of radioactive waste.

"Cooking Without A Grain of Salt" Cook Book Just Published

Anyone can cook without salt, but it takes an expert to turn out an appetizing and varied diet minus seasoning. Now anyone can be an expert in this field if they have the new cook book "Cooking Without a Grain of Salt."

Written by Elma W. Bagg, published by Double-

Continued

day and selling for $4.95, the book explains over 250 highly palatable recipes. It is intended as an aid to those on low-salt diets and contains an admonition from the author to adopt the recipes only on the advice of the doctor.

AMA Motion Picture Catalog Now Available to Physicians

The most complete catalog ever compiled of medical and surgical motion pictures has been published by the American Medical Association.

The new book, *Medical and Surgical Motion Pictures*, lists over 3,000 available motion pictures dealing with every phase of the healing arts. Up-to-the-minute listings were made possible through computer processing.

The catalog will be an invaluable tool in the training of students, nurses and graduate physicians. It is aimed at the potential user of films of a professional nature and includes films for personnel in ancillary fields of medicine.

The film listings are divided in three general categories: basic sciences, clinical medicine and surgery and para-medical sciences. It is then subdivided into some 600 specialty subjects. The films are listed alphabetically under each specialty.

Included with the listing is a brief summary, running time, black and white or color, silent, optical or magnetic sound, year of release, language versions other than English, names of the authors and producers, and the name and the address of the primary rental source.

The catalog is available at the cost price of $5.00 to addresses in the U.S., U.S. Possessions and Canada; $5.50 to other foreign addresses. Write to the American Medical Association, 535 N. Dearborn St., Chicago, Illinois 60610.

Physicians, Dentists Attend "500" Preview Golf Tournament

Approximately 150 golfing enthusiasts attended the "500" Preview Golf Tournament in May at the Ulen Country Club in Lebanon. The group was made up of physicians, dentists, druggists and members of the Indiana Society of Medical Service Representatives, the sponsoring group.

Robert Callis, D.D.S., won the trophy for low gross, with a score of 71. Dr. Howard Beaver won the low net trophy with a net score of 64. A dinner at which the trophies and prizes were awarded was held that evening. ◄



GREGORY S. LUMBRA, 17, a senior at University High School in Bloomington, won one of the two top awards of the American Medical Association during the 15th National Science Fair-International May 6-9 in Baltimore, Md. He is pictured here with Dr. Edward R. Annis, Miami, Fla., AMA president, and his co-winner, Miss Gail M. Houston of Goodwater, Ala., at the Health Awards Banquet, co-hosted by the AMA, the American Dental Association, the American Pharmaceutical Association and the American Veterinary Medical Association. Their studies, chosen from a field of over 400 entrants by finalists from the U.S., South America, Europe and Asia, were on "Thymus Research" and "Rous Sarcoma," respectively.

INDIANA STATE BOARD OF HEALTH

MONTHLY REPORT — May, 1964

Disease	May 1964	Apr. 1964	Mar. 1964	May 1963	May 1962
Animal Bites	1068	904	427	1029	1234
Chickenpox	483	723	835	758	576
Conjunctivitis	142	207	151	77	131
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	45	71	61	111	65
Gonorrhea	325	312	279	233	Not Available
Impetigo	69	146	134	75	110
Infectious Hepatitis	35	71	53	81	141
Infectious Mononucleosis	62	97	41	31	80
Influenza	202	506	818	240	646
Measles (Rubeola-Rubella)	5019	6868	4541	1556	2140
Meningitis, Meningococcal	2	9	8	3	1
Meningitis, Other	7	9	5	12	3
Mumps	751	1422	1047	519	603
Pertussis	41	53	26	29	25
Pneumonia	200	344	157	154	306
Poliomyelitis	0	0	0	1	0
Streptococcal Infections	468	903	766	565	592
Syphilis					
Primary & Secondary	1	6	3	6	Not Available
All Other Syphilis	98	105	101	111	Not Available
Tinea Capitis	14	27	20	8	16
Tuberculosis (Active)	101	169	114	193	119



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Iron (as Ferrous Betaine Citrate)	30 mg.
Cobalt (as Cobaltous Betaine Citrate)	0.1 mg.
Manganese (as Manganese Betaine Citrate)	1.0 mg.
Zinc (as Zinc Betaine Citrate)	1.25 mg.
Magnesium (as Magnesium Betaine Citrate)	6.0 mg.
Vitamin B-1	1.5 mg.
Vitamin B-2	1.2 mg.
Vitamin B-12	6.0 mcg.
Niacinamide	10 mg.
Panthenol	10 mg.

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FUTURE MEETINGS, SEMINARS, COURSES

Annual Meeting of American Academy of Physical Medicine, Rehabilitation

The annual meeting of the American Academy of Physical Medicine and Rehabilitation will be held on August 24-27 at the Statler-Hilton Hotel, in Boston, Mass.

It will consist of formal lectures, as well as educational seminars in the field of disability evaluation, forensic physiatry, and muscle diseases. For further details write the academy at 30 N. Michigan Ave., Chicago, 60602.

Annual Otolaryngologic Assembly Set for October 3-9 in Chicago

The Department of Otolaryngology of the University of Illinois College of Medicine and the new Illinois Eye and Ear Infirmary at the Medical Center, Chicago, will present an intensive postgraduate basic and clinical program Oct. 3-9.

This assembly for practicing otolaryngologists offers a condensed one week program. It is designed to bring to specialists fundamental information and a wide variety of current advances in medical and surgical management. Basic sciences are reviewed by means of discussions augmented by visual aids.

Interested physicians should direct communications to the Department of Otolaryngology, University of Illinois College of Medicine at the Medical Center, 1853 W. Polk St., Chicago, 60612.

VIII International Congress on Diseases of the Chest Set for October

The VIII International Congress on Diseases of the Chest will be conducted at Mexico City October 11 to 15. A complete program of lectures and symposia by international authorities, a scientific exhibit and appropriate social activities are planned.

A registration fee of $50 applies to all doctors and $30 to their wives and non-medical guests. The fee covers all charges for the numerous social gatherings.

Further details and a registration form may be obtained by writing Dr. Miguel Jimenez, Bloque B-3er Piso, Ave., Cuahtemoc 330, Mexico 7, D.F.

Laryngology, Bronchoesophagology Course Offered November 9-21

The Department of Otolaryngology, University of Illinois College of Medicine at the Medical Center, will conduct a postgraduate course in Laryngology and Bronchoesophagology November 9-21 under the direction of Paul H. Holinger, M.D. It will be held at the new Illinois Eye and Ear Infirmary, 1855 W. Taylor St., Chicago.

Registration will be limited to fifteen physicians who will receive instruction by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures.

Interested registrants will please write directly to the Department of Otolaryngology, University of Illinois College of Medicine, 1853 W. Polk St, Chicago, Illinois 60612.

American Assn. of Electromyography And Electrodiagnosis Sets Meeting

The annual meeting of the American Association of Electromyography and Electrodiagnosis will be held on August 23, at the Statler-Hilton Hotel, Boston, Massachusetts.

Please address all communications to: Max K. Newman, M.D., 16861 Wyoming Ave., Detroit, Michigan. 48221.

Annual Meeting of A.M.W.A. to be September 24-27 in Philadelphia

The American Medical Writers' Association—a professional society of people engaged or interested in various aspects of medical communication—will hold its 21st annual meeting, Sept. 24-27, 1964, in Philadelphia. Dr. W. D. Snively, Jr., Evansville is president of the organization.

The A.M.W.A.'s objectives are to improve the quality and efficacy of communications within the medical world, to provide a forum and publication medium for the interchange of views among its members, and to improve the status and recognition of the medical communicator.

The association holds annual meetings at which outstanding exponents of various aspects of medical communication submit their opinions and experiences to their colleagues. The A.M.W.A. also publishes a monthly *Bulletin*, reporting developments in this field, news of the Association's six local chapters and its 1800 members, together with original articles, book reviews and other items of interest.

Other A.M.W.A. functions include the maintenance of a medical manuscript service, a roster of qualified lecturers on medical communication, the presentation of fellowships and awards for "distinguished service in medical communication" to outstanding individuals and medical publications, and the provision of scholarship assistance to students of medical journalism.

Membership is available to any person "actively engaged or interested in any aspect of communi-

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cation in the medical and allied professions". . . . Dues are $15 per year and the national office of A.M.W.A. is located at 2000 P Street, N.W., Washington, D. C., 20036.

Mount Sinai Hospital Sets Course in Psychotherapy

The Department of Neuropsychiatry, Mount Sinai Hospital, Chicago, announces its 1964-65 Continuing Education Program in Psychiatry and Psychotherapy for physicians and those in professions related to psychiatry. These courses will be held bi-weekly from October, 1964 through March, 1965 under the direction of H. H. Garner, M.D.

Registration will be limited to 25 physicians who will receive instruction by patient demonstration and didactic lectures. The American Academy of General Practice offers Category 1 credit for some of these courses.

Interested registrants should write directly to the Department of Neuropsychiatry, L 206, Mount Sinai Hospital, 1755 W. 15th St., Chicago 8.

Annual Postgraduate Gastroenterology Course Listed for New York in October

The annual course in Postgraduate Gastroenterology of the American College of Gastroenterology will be given at The Roosevelt Hotel, New York City, October 22, 23, 24.

Moderators for the course will again be Dr. I. Snapper, Director of Medical Education, Brookdale Hospital Center, Brooklyn, N. Y. and Dr. John L. Madden, Clinical Professor of Surgery, New York Medical College and Director of Surgery, St. Clare's Hospital, New York, N. Y.

For further information and enrollment, write to the American College of Gastroenterology, 33 W. 60th St., New York, N. Y. 10023.

American Ob-Gyn Board Sets Part I Written Exam

The next scheduled Part I (written) examination of this board will be held at various examining centers in the United States, Canada, and military bases outside of the continental United States on Friday, December 11 at 2:00 p.m. Candidates eligible to take this examination will be notified on or about November the first where to appear for examination.

The 1964 bulletin of this board is now available and prospective candidates are urged to request this brochure and thoroughly familiarize themselves with the changes in rules, regulations, and schedules of examination to take place during the next three years.

Bulletins may be obtained by writing to Clyde L. Randall, M.D., Secretary, American Board of Obstetrics and Gynecology, 100 Meadow Rd., Buffalo, New York 14216. ◄

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County, District News

First District

Dr. Frank W. Oliphant, Mount Vernon, has been elected president of the First District. Other new officers are: Drs. Eugene Austin, vice-president; Wallace Adye, secretary-treasurer; Gilbert Wilhelmus, alternate councilor and George Willison, Blue Shield representative. All of the officers other than the president are from Evansville.

Second District

New officers of the Second District are: Drs. Joe E. Dukes, Dugger, president and J. S. Brown, Carlisle, secretary. Dr. Anthony R. Lasich, Indianapolis, who is also a lawyer, spoke on "Trends in Malpractice" at the May 28 meeting at Vincennes. Dr. Joe Black, president-elect of ISMA, also made a short speech.

Third District

Newly elected president of the Third District is Dr. Edward J. Ploetner, Jasper. Dr. Arthur L. Wagner, also of Jasper, was elected secretary. Dr. Donald M. Kerr, Bedford, was elected councilor and Dr. E. L. Wallace, New Albany, was chosen alternate councilor to fill the unexpired term of Dr. Kerr.

Fourth District

The Fourth District has elected the following as its new officers: Drs. F. D. Ellis, North Vernon, president; Robert Zink, Madison, vice-president and S. B. Berkshire, North Vernon, secretary-treasurer. Dr. Robert Reid, Columbus, was elected to fill the unexpired term of Dr. Black. Dr. Jack Shields, Brownstown, was chosen alternate councilor.

Sixth District

Officers of the Sixth District for 1964 will be: Drs. Charles H. Loomis, Richmond, president; William E. Murray, New Castle, vice-president and John J. Farrell, Jr., Greenfield, secretary. Dr. William Tindall, Shelbyville, was re-elected councilor. Dr. Ottis N. Olvey, assistant treasurer; Mr. James Waggener, executive secretary and Robert Amick, field secretary, represented ISMA at the May 14 meeting.

Seventh District

Dr. A. M. Donato, Indianapolis, is the newly elected president of the Seventh District. Dr. William C. Stafford, Plainfield, is the new vice-president and Dr. James H. Gosman, Indianapolis, secretary-treasurer. The 1965 meeting will be held in Indianapolis.

Eighth District

President of the Eighth District for the coming year will be Dr. Warren L. Bergwall, Muncie. Assisting him will be Dr. David J. Dietz, Muncie, secretary-treasurer. Dr. Fletcher McDowell, Muncie, was re-elected Blue Shield representative. Dr. Carl D. Martz, Indianapolis, spoke on the "Indianapolis Coliseum Disaster" at the meeting. Mr. Waggener, Howard Grindstaff, field secretary and Dr. Ralph Everly, chairman of the Executive Committee, represented ISMA at the meeting.

Ninth District

Dr. Harry T. Stout, Frankfort, is the new president of the Ninth District. Other new officers include: Drs. Milton W. Erdel, Frankfort, vice-president and E. K. Williams, secretary. All of the new officers are from Frankfort. Dr. Peter Petrich, Attica, was elected councilor and Dr. Robert Vermilya, Lafayette, elected Blue Shield representative. The 1965 meeting will be May 20 at Frankfort.

Twelfth District

Dr. Marvin E. Priddy, Fort Wayne, is the new president of the Twelfth District. Vice-president is Dr. Frederic L. Schoen, Fort Wayne and Dr. Warren L. Niccum, Columbia City, the new secretary-treasurer. Dr. Milton F. Popp was re-elected councilor, Dr. William R. Clark, alternate councilor and Dr. Mahlon F. Miller, Blue Shield representative. The 1965 meeting will be held May 19, 1965 at Fort Wayne.

Cass

The Cass County Medical Society met May 4 to hear Dr. John Beeler, Indianapolis, speak on "Radiology for Problems of the Eye, Ear, Nose, Throat and Esophagus." There were 26 members present.

Clinton

Fourteen members of the Clinton County Medical Society met May 14 to hear Field Secretary Howard Grindstaff discuss federal legislation.

Dearborn-Ohio

Mr. Kenneth Moeller, representative of the Medical Protective Company, spoke on "Malpractice Suits" before the May 14 meeting of the Dearborn-Ohio County Medical Society. There were 13 members present.

DeKalb

Dr. Clifford Shultz, Butler, has been elected president of the DeKalb County Medical Society. Other new officers are Drs. John C. Harvey, Auburn, vice-president and Floyd B. Coleman, Waterloo, secretary-treasurer.

Fort Wayne

Dr. Mahlon F. Miller has been elected president of the Fort Wayne Medical Society. Other new officers are: Drs. George C. Manning, Jr., president-elect; Robert P. Schloss, secretary and Jerry L. Stucky, treasurer.

Lake

Dr. Leo Zimmerman, professor of surgery at the

Chicago Medical School, discussed "Surgical Aspects of Breast Cancer" with members of the Lake County Medical Society at their May 13 meeting. There were 83 doctors and wives present.

Owen-Monroe

The Owen-Monroe County Medical Society met May 28 to view a film on "Cancer of the Throat and Nose." There were 21 members present.

Shelby

A combined panel of two physicians and two lawyers discussed "Medicolegal Problems" before the May 6 meeting of the Shelby County Medical Society. Nineteen members attended the combined meeting with the Shelby County Bar Association.

Starke

Dr. J. R. Matthew spoke on "What the General Practitioner Can Do for Psychiatry" at the May 5 meeting of the Starke County Medical Society. Films on phenylketonuria also were shown by a representative of Mead Johnson Company.

St. Joseph

Newly elected officers of the St. Joseph County Medical Society are: Drs. H. A. Schiller, president; R. W. Holdeman, president-elect and Nicholas C. Johns, secretary-treasurer. There were 44 members present.

Vanderburgh

Dr. Harold E. Kleinert, associate professor of surgery at the University of Louisville Medical School, spoke on "Acute Hand Injuries" at the May 12 meeting of the Vanderburgh County Medical Society.

Wayne-Union

"Genetics in Medical Practice" was the topic chosen by Dr. A. Donald Merritt, geneticist from the I.U. Medical School, when he spoke at the May 12 meeting of the Wayne-Union County Medical Society. The 42 members present paid tribute to Dr. F. P. Buche, Richmond, who was celebrating his 84th birthday and his 58th year of practice.

Whitley

Dr. Linus Minick discussed "Inflammations—Acute and Allergic" with 16 members of the Whitley County Medical Society present at the May 12 meeting. ◄

66 . . . 99

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Deaths

Herma A. Beck, M.D.

Dr. Herma A. Beck, Lebanon and Boone County health officer for more than 25 years, died March 13 at Lebanon. He was 83.

Dr. Beck was born in Boone County. A 1904 graduate of the I. U. School of Medicine, Dr. Beck practiced in Lebanon from 1906 until his retirement last year. He was a Senior Member, a member of the ISMA 50-Year Club and the Boone County Medical Society.

Benjamin T. Daggy, M.D.

Dr. Benjamin T. Daggy, 77, a practicing physician for 55 years, died May 15 at Richmond.

Dr. Daggy, a native of Little Rock, Ark., began his practice in Petersville, Ind., and in Indianapolis. He went to Richmond after World War I and practiced medicine there for 44 years. He served as a medical officer in both World War I and World War II. Dr. Daggy was a member of the Wayne-Union County Medical Society.

115th Annual Convention

INDIANA STATE

MEDICAL ASSOCIATION

October 12-15

Murat Theater

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RESERVATIONS . . .

Harry H. Heinrichs, M.D.

Dr. Harry H. Heinrichs, retired Indianapolis physician, died April 27 at the age of 83.

Dr. Heinrichs, a practicing physician in Indianapolis for more than 50 years, retired eight years ago. He was a Senior Member, a member of the 50-Year Club and of the Marion County Medical Society.

John W. Little, M.D.

Dr. John Little, 91, former Indianapolis physician, died May 29 at Decatur, Ill., where he had lived the last four years with his son.

Dr. Little received his law degree from DePauw University in 1894 and a science degree in 1900. He taught biology at DePauw for five years and later at several high schools. He received his medical degree from the old Central College of Physicians and Surgeons and began practicing medicine in 1908. He was a member of the ISMA 50-Year Club and the Marion County Medical Society.

Francis Prenatt, M.D.

Dr. Francis Prenatt, member of the Madison State Hospital staff for the last 31 years, died May 16 at Madison at the age of 69.

Dr. Prenatt was born in Jefferson County and was graduated from Hanover College and the I. U. School of Medicine. He practiced medicine at the Dayton State Hospital, Dayton, Ohio; the National Home for Disabled Soldiers and Central State Hospital at Indianapolis before going to Madison. He served in World War I and was an ISMA delegate from Jefferson-Switzerland County Medical Society for many years.

John L. Reck, M.D.

Dr. John L. Reck, 81, a Hamilton County physician 52 years, died March 13 at Indianapolis.

Dr. Reck had practiced medicine at Sheridan from 1910 until his retirement in 1962. A graduate of the I. U. School of Medicine, Dr. Reck attended Ohio Northern University and taught school for two years before entering I. U. in 1904. He was a member of the Hamilton County Medical Society.

Raymond Sorenson, M.D.

Dr. Raymond Sorenson, 60, a urologist at Kokomo since 1946, died there May 8.

Dr. Sorenson attended the University of South Dakota and received his M.D. degree from Northwestern University in 1929. He served in World War II, was president of the Howard County Medical Society and was Chief of Staff at St. Joseph Memorial Hospital. He was also instrumental in securing the original certification of the hospital. ◄

Association News

EXECUTIVE COMMITTEE

April 25, 1964

Present: Ralph V. Everly, M.D., chairman; Joe M. Black, M.D.; Kenneth O. Neumann, M.D.; Irvin W. Wilkens, M.D.

Frank B. Ramsey, M.D., editor of *The Journal*, Ralph Hamill, attorney, and James A. Waggener, executive secretary.

Membership Report

Number of members as of April 30, 1963	4,259
1964 members as of April 24, 1964:	
Full dues paying	3,726
Residents and interns	112
Council remitted	38
Senior	324
Honorary	3
Military	50
Total 1964 members as of April 24, 1964	4,253
Number of members as of April 30, 1963	4,259
Loss over last year	6
Number of AMA members as of April 24, 1964	4,141
Total 1963 AMA members as of April 30, 1963	4,140
Gain over last year	1
1964 AMA members: Dues paying	3,613
Exempt, but active	528
	4,141
Number who have paid state dues but not AMA dues as of April 24, 1964	112

Headquarters Office

Changes in the retirement plan for certain employees were approved on motion of Drs. Wilkens and Neumann.

Report on the medical-legal conference was made by Mr. Hamill.

Building Matters

The chairman of the Building Committee told of the gift of $1,000.00 from the Woman's Auxiliary, to be used for the purchase of additional tables and chairs for the basement. The secretary was instructed to write a letter of appreciation to the auxiliary for this generous gift.

The secretary requested that a policy be set by the Executive Committee concerning the price to be charged for the use of the building when used by groups at hours other than business hours of the association. He pointed out that the Council had approved the recommendation of the Building Committee that a charge be made but no fee had been designated. This was discussed, and upon motion of Drs. Wilkens and Neumann, a fee of $25.00 is to be charged for use of the building during other than regular business hours. This money will be used for extra janitorial service, personnel working overtime and for utilities.

Treasurer's Office

The treasurer reported on the balances in funds as of March 31 and the status of funds in the budget. The report was approved on motion of Dr. Wilkens and Neumann.

Annual Convention, Indianapolis, October 13, 14 and 15, 1964

The secretary reported the question had been raised concerning holding the final meeting of the House of Delegates in the headquarters building. It was the feeling of the Executive Committee that there was a good possibility that it might be a good idea to try this during the 1964 convention. It was agreed, in any event, that the House of Delegates final meeting should begin at 2:30 rather than 2:00 p. m. as scheduled. On motion of Drs. Wilkens and Neumann, this question was to be referred to the Council for its decision.

The guest list for the President's Luncheon was discussed and the secretary was instructed to put this on the agenda for the next Executive Committee meeting.

Dr. Henry F. Nolting, Indianapolis, is to be requested to act as chairman of arrangements for the Fifty-Year Club reception, and Dr. Merrill S. Davis, Marion, is to be asked to make the response at the President's Luncheon.

Legislation

National:

The secretary read from the Washington Report on Medical Sciences comments concerning the Saltonstall Bill which has been introduced before the Congress.

Local:

The secretary reported that he had discussed the implementation of the Kerr-Mills Bill in Indiana with Mr. Albert Kelly of the Department of Public Welfare and he assured him that he was working on the plan and did propose to call a meeting of the Advisory Committee prior to May 13.

The secretary also reported that he had had a call from the Podiatrists' Association, asking if the state medical association would object to the podiatrists attempting to amend the Kerr-Mills Bill to include podiatrists.

The secretary also reported on a letter being circulated in some sections of the state by the chiropractors to employers to determine whether or not employers permitted their employees to use the services of a chiropractor under the Workmen's Compensation program.

Organization Matters

The secretary reported that the president had asked that he bring before the committee a request for $100.00 or $150.00, to be used as an honorarium for procuring Dr. Francis J. Braceland of Philadelphia as a speaker for a mental health meeting in the fall. Upon motion of Dr. Neumann, taken by consent, the sum of $100.00 was appropriated for this purpose.

A letter from Dr. William G. Bannon, chairman of the I-HOPE Board, was read in which he requested the association to determine the feasibility and the legality of the association billing for membership in I-HOPE at the same time it bills

for state dues. By consent this question was to be referred to the Council.

The secretary read a letter from the Student American Medical Association requesting that the association again support the Student AMA with a $100.00 sustaining membership for 1964-1965. On motion of Drs. Neumann and Wilkens, $100.00 was authorized for this purpose.

A letter from the Chicago Committee for Project Hope, requesting cooperation of the Indiana State Medical Association in publicizing this organization and appealing to members of the state medical association to support it, was tabled.

A letter from M. E. Rougraff, M.D., summarizing the activities of the Indiana Health Insurance Council, was reviewed for the information of the committee.

The secretary reported that the staff had been working with the State Board of Health for the development of a TV classroom series on the Medical Self-Help program. The proposal was approved by consent.

The secretary called attention to the changes in the meeting dates of some of the medical districts.

A letter from the Vanderburgh County Medical Society concerning the expulsion of a member and raising the question about refunding state dues was deferred until the next meeting of the committee.

New Business

A paper, prepared by a member of the Blue Shield Board, outlining a proposal for the care of the aged, was referred to the Council by consent.

A letter from Dr. Lowell Thomas concerning the question of professional services being provided under the Blue Cross certificate being in conflict with the Medical Practice Act was referred to the Council for discussion.

Journal

The committee reviewed the report of the State Journal Advertising Bureau, which was to be brought to the attention of the Council at its next meeting.

There being no further business the Committee adjourned to meet again Sunday evening, June 21, at the Fairmount Hotel, San Francisco, unless the chairman finds it necessary to call a meeting in the intervening period. ◄

EXECUTIVE COMMITTEE

May 20, 1964

Present: Ralph V. Everly, M.D., chairman; Joe M. Black, M.D.; Kenneth O. Neumann, M.D.; Irvin W. Wilkens, M.D., Ottis N. Olvey, M.D.

Frank B. Ramsey, M.D., editor of *The Journal;* J. A. Waggener, executive secretary.

AMA delegates: Harold C. Ochsner, M.D.; Francis L. Land, M.D.; Guy A. Owsley, M.D.; Jack E. Shields, M.D.

AMA alternate delegates: James H. Gosman, M.D.; Robert M. Brown, M.D.; Frank H. Green, M.D.; William B. Challman, M.D.; John M. Paris, M.D.

AMA trustee: Lester D. Bibler, M.D.

Guest: Edward R. Annis, M.D., president, American Medical Association.

The Executive Committee and the AMA delegates discussed the forthcoming meeting of the American Medical Association in San Francisco.

By unanimous vote, on motion of Dr. Neumann, the president of the association was designated as chairman of the delegation.

Upon motion of Dr. Brown, seconded by Dr. Owsley, Dr. E. S. Jones was named floor leader for the delegation.

It was decided that this meeting would take the place of the one which is normally held preceding the evening session of the House of Delegates of the AMA inasmuch as most of the Indiana representatives will be attending the AMPAC dinner.

Headquarters Office

A letter from the Wil-Ten Company, Inc., proposing that the Association allow them to use fifteen parking spaces on week days in exchange for an exit to Fortieth Street was discussed.

Treasurer's Office

The treasurer reported on the balances as of April 30, 1964.

Annual Convention, Indianapolis, October 13, 14 and 15, 1964

The guest list for the President's luncheon was discussed and it was agreed that this should be put on the agenda for the next meeting of the committee.

Legislation

National:

The secretary read a letter from the AMA reporting that the national convention of Methodist churches had not adopted a resolution in favor of Medicare.

Organization Matters

The secretary read a note from the chairman of the Commission on Medical Education and Licensure requesting that authorization be given to Dr. Joel Salon, a member of the commission, to visit Albany Medical College to look over its postgraduate medical education program. No action was taken on this, but the secretary was instructed to request the commission to set forth the reasons why this request was made.

A resolution from the Vanderburgh County Medical Society for presentation to the House of Delegates of the Indiana State Medical Association in October was read for the information of the committee.

A letter from James R. Davis, Columbus, Indiana, soliciting financial assistance to complete his high school science project was reviewed and it was voted that this request should be referred to the Bartholomew-Brown County Medical Society.

A letter of appreciation from Elmer C. Paul, chief of Protective Devices Section, Traffic Safety Branch, Division of Accident Prevention, Department of Health, Education and Welfare, was read for the information of the committee.

A letter from the Minnesota State Medical Association urging the association to join them in urging the American Medical Association to solicit federal funds for full-time Civil Defense staffs was read. No action taken.

The secretary reported on the changes in the VA Hometown Fee Schedule.

The suspension of a member of a county medical society, which was discussed at a previous meeting of the committee, was again brought up and the committee was informed that the Council had decided to make a dues refund on a pro-rata basis.

The Journal

The advertising request of Planned Investment Company was presented for approval. It was agreed that this matter should be discussed with Dr. Ramsey and the legal counsel and if they approved, the ad could be inserted in *The Journal.*

A letter from the Indiana University School of Medicine requesting that a copy of the State Medical *Journal* be made available to the Dean's office of the University was approved by consent.

There being no further business, the committee adjourned to meet again upon the call of the chairman. ◄

THE COUNCIL

April 26, 1964

The Council of the Indiana State Medical Association convened for its spring meeting at 10:00 a. m., Sunday, April 26, 1964, in the headquarters office building, 3935 North Meridian Street, Indianapolis, with Dr. Kenneth O. Neumann, chairman, presiding.

Roll call showed the following present:

Councilors:

First District—P. J. V. Corcoran, Evansville
Gilbert M. Wilhelmus, Evansville, alternate
Second District—E. T. Edwards, Vincennes
Third District—John M. Paris, New Albany (also AMA alternate delegate)
Donald M. Kerr, Bedford, alternate
Fourth District—Joe M. Black, Seymour (also president-elect)
Robert M. Reid, Columbus, alternate
Fifth District—V. Earle Wiseman, Greencastle
A. W. Cavins, Terre Haute, alternate
Sixth District—William R. Tindall, Shelbyville
Seventh District—Albert M. Donato, Indianapolis
Eighth District—Donald R. Taylor, Muncie
Paul Sparks, Winchester, alternate
Ninth District—Kenneth O. Neumann, Lafayette
Tenth District—Lowell H. Steen, Whiting
Lee Trachtenberg, Hammond, alternate
Eleventh District—E. S. Rifner, Van Buren
Twelfth District—Milton F. Popp, Fort Wayne
William R. Clark, Fort Wayne, alternate
Thirteenth District—Jene R. Bennett, South Bend
Raymond E. Nelson, South Bend, alternate

Officers:

Irvin W. Wilkens, Indianapolis, treasurer
Ottis N. Olvey, Indianapolis, assistant treasurer

Journal:

Frank B. Ramsey, Indianapolis, editor

Executive Committee:

Ralph V. Everly, Indianapolis, chairman

Guests:

Harold C. Ochsner, Indianapolis, AMA delegate
E. S. Jones, Hammond, AMA delegate
Francis L. Land, Fort Wayne, AMA delegate
Guy A. Owsley, Hartford City, AMA delegate
Jack E. Shields, Brownstown, AMA delegate
Robert M. Brown, Marion, AMA alternate delegate
William B. Challman, Mount Vernon, AMA alternate delegate
John I. Nurnberger, Indianapolis, acting dean, I. U. School of Medicine
Charles Fisch, Indianapolis, chairman, Convention Arrangements
Lloyd J. Banks, Indianapolis, director, Enrollment Division, Blue Cross-Blue Shield
Guy W. Spring, Indianapolis, executive director, Blue Cross Hospital Service
Richard C. Kilborn, Indianapolis assistant executive vice-president, Blue Cross-Blue Shield
D. S. Megenhardt, Indianapolis, Professional Advisory Committee, Blue Cross
Dr. H. Lawrence Wilsey and Rockwell Schulz, of Booz, Allen & Hamilton, Chicago

Staff:

Ralph Hamill, attorney
Robert J. Amick, field secretary
Howard Grindstaff, field secretary
J. A. Waggener, executive secretary
K. W. Bush, administrative assistant

On motion of Drs. Steen and Edwards, minutes of the meeting held January 12, 1964, were approved as printed in the March, 1964 *Journal.*

Reports of Councilors

DR. BLACK, Fourth District, reported that he had resigned as councilor of the Fourth District and his successor would be elected at the Fourth District meeting on May 13.

DR. WISEMAN, Fifth District, reported that

the date for the Fifth District meeting would be set at a meeting to be held within the next week.

DR. STEEN, Tenth District, announced that the Tenth District meeting on May 13 would be held at Phil Smidt's in Whiting, and not at Gary, as listed.

Indiana licensing law. Dr. Steen presented the request of "a certain segment of the Lake County Medical Society" to recommend to the Council that it refer to the Commission on Legislation, or whatever appropriate body the Council may designate, the matter of reviewing and studying the Indiana licensing law. **It was taken by consent that this matter shall be referred to the Commission on Legislation.**

Matters Referred to Council by Executive Committee

DR. RALPH V. EVERLY, chairman, presented the following matters:

1. *Resignation of Dr. George Willison, Evansville, as member of Executive Committee.* **By ballot Dr. G. O. Larson of LaPorte was elected a member of the Executive Committee for 1964 to succeed Dr. Willison.**

2. *Plan for Total Medical Care.* On recommendation of Dr. Steen, this plan, prepared by Dr. Milton B. Gevirtz of Munster, and discussed by the Executive Committee at its meeting on April 25, was tabled until the next meeting of the Council, in order that the Lake County Medical Society Council and the Lake County Prepaid Medical Care Committee Plan may have an opportunity to study the plan and take official action on it.

3. *The matter of billing members for I-HOPE* at the same time dues statements are sent out was discussed by Judge Hamill. **On motion of Drs. Paris and Steen this matter was tabled until the next Council meeting,** to allow time for the legal counsel to obtain complete information on the subject.

4. *Final meeting of House of Delegates, October, 1964.* Following discussion by Drs. Edwards and Everly, **on motion of Drs. Bennett and Wiseman, the Council voted not to hold this meeting in the headquarters building.**

5. *Letter from Dr. Lowell Thomas,* chairman of the Ad Hoc Committee of Blue Cross-Blue Shield, concerning the transfer of payment of fees for radiology and pathology services from Blue Cross to Blue Shield was read, as was a resolution concerning relations between physicians and hospitals which was adopted by the Tennessee Medical Association Council.

Discussed by Judge Hamill, Drs. Bennett, Paris, Edwards and Taylor. Dr. Edwards suggested that prior to more definitive action by the Executive Committee, and to act more intelligently on budgetary requests, two cost figures should be obtained: (1) an estimate of the legal expense in following up preliminary studies on Dr. Thomas' letter, and (2) expense involved to determine the transfer cost in the insurance realm. **This suggestion was taken by consent.**

On motion of Drs. Bennett and Wiseman, the resolution of the Tennessee Medical Association was tabled for the present time.

6. *Science Fair support.* Following discussion, **Dr. Paris' motion that the Indiana State Medical Association support the National Science Fair-International in the amount of $500.00 was lost for want of a second.** It was brought out in the discussion that many of the county medical societies support this project on a local basis and it was the feeling of the Council that the members should not be asked to contribute on a statewide basis also.

7. *Chiropractic activities.* Drs. Taylor and Paris discussed the organized efforts of the chiropractors to broaden their services and increase their influence.

It was suggested that the Council might like to consider requesting the Commission on Legislation to introduce a bill in the 1965 General Assembly to clarify the definition of a physician in the Workmen's Compensation Laws of the state, but no action was taken by the Council.

8. *President of AMA.* **On motion of Dr. Paris, seconded by many, the Council voted to support Dr. Don E. Wood for president of the AMA,** and instructed that letters be mailed as soon as possible by the headquarters office to all AMA delegates announcing the ISMA Council's support of Dr. Wood.

Reports of Officers

DR. JOE M. BLACK, president-elect, reported that he had attended several meetings on behalf of Dr. Wood, president, who had been busy traveling to various parts of the United States for AMPAC. He spoke of the Vanderburgh County Medical Society meeting, and Junior-Senior Day, both of which were excellent meetings, saying, "I want to acknowledge the fine work that the Commission on Public Health, Dr. Rifner and Dr. Lamb have been doing on Junior-Senior Day. This is one of the finest meetings we have every year, and it certainly was a pleasure to represent the state medical association there and see what a fine job our men are doing with it."

Dr. Black also reported attending a Blue Cross-Blue Shield meeting.

The chairman, on behalf of the Council, thanked Drs. Rifner and Lamb and the Commission on Public Health for the tremendous job they have done with the Junior-Senior Day program.

DR. IRVIN W. WILKENS, treasurer, presented statements listing the amounts in the various association accounts and showing total resources as of March 31, 1964, amounting to $193,325.96.

As of April 23, 1964, Dr. Wilkens reported the total cash bank balance as $69,584.95, composed of the General Fund of $37,000.00 plus; *The Journal* Fund, $6,000.00 plus; Student Loan Fund of $9,000.00 plus; Medical Defense of $7,000.00 plus; Kitchen Fund of $1,000.00 plus, and Building Fund of $8,000.00 plus. Dr. Wilkens commented, "So as of this moment we are in a better state

financially than we have been for the past four years."

Delegates to the AMA. DR. E. S. JONES discussed some of the activities of the American Medical Association and spoke also of the good representation of Indiana physicians on the various AMA committees and councils, as follows: Don Wood reappointed a member of the Council on Legislative Activities; Rolla N. Harger (Ph.D.), reappointed a member of the Subcommittee on Chemical Tests for Intoxication of the Committee on Medicolegal Problems; John B. Hickam, reappointed a member of the Council on Postgraduate Programs; Norman R. Booher, member of the Council on Voluntary Health Agencies; Clyde G. Culbertson, reappointed a member of the Committee on Blood; Willard S. Krabill, Goshen, reappointed a member of Committee on Medicine and Religion, and E. S. Jones, chairman of the Council on Occupational Health and reappointed a member of the Committee on Mental Health in Industry.

DR. FRANCIS LAND commented on the survey being made by the AMA of the physicians available in the different specialties and in general practice in the various communities, and also on the Millis Commission, which is composed of people outside of medicine—jurists, educators, etc. "They are meeting and interviewing representatives of all branches of medicine and they have sort of a carte blanche authority to disseminate their information without approval of the Board of Trustees or the Council on Medical Education. It will be interesting to watch for their comments."

Dr. Land also mentioned that the Indiana resolution which was introduced some six years ago by Dr. Kenneth Olson had been completed; the report was accepted last year in June—the essentials on internship have been rewritten—and will be presented to the House of Delegates in June, 1964. "In essence the resolution says that an out-patient department will not be required in order to offer internships Another thing of interest to you is that a resolution will be proposed by the Council on Medical Education that straight internship be abolished effective July 1, 1965."

DR. GUY A. OWSLEY discussed the AMA disability program, pointing out that the policy offered by the AMA is not effective until the 366th day of disability. (Discussed also by Drs. Steen and Edwards).

DR. FRANK B. RAMSEY, editor of *The Journal*, reported that for the six months' period ending March 31, 1964, *The Journal* showed a profit of $1,500.00. "The roster number which we will publish in June will more than take up our $1,500.00 black figure, so that we probably are very close to even for this part of the year. Our advertising last year averaged 40 pages per month. In January of this year we had 30 pages of advertising. At the present time that has increased until we now have an average of 32 pages —a slight increase."

Dr. Ramsey discussed the annual report of the State Medical Journal Advertising Bureau, copy of which was presented to each councilor, giving the yearly income since 1946. "In relation to the advertising bureau, like our *Journal*, there has been a slight indication of improvement in advertising revenue during the last two months."

Dr. Ramsey, in reply to a question regarding whether or not the change in *Journal* printers had been satisfactory and up to par on savings, said: "It is very satisfactory on savings. The new binding has been satisfactory. I have had innumerable compliments on binding *The Journal* in its present form. Everyone finds it much easier to read, much easier to handle."

The cost of publishing the roster, and the feasibility of issuing a roster bi-annually instead of annually were discussed by Drs. Steen, Edwards, Paris and Ramsey. **By consent, this matter was referred to the Council Committee of Business Consultants for *The Journal*, with the request that this committee report to the Council at its July meeting.** In the meantime, the secretary is to supply the committee with figures on the cost of publishing the roster.

Economic and Organization Matters

1. *Remission of state dues.* The Council voted the remission of state dues as follows:

Gibson County—One member, retired because of illness, **on motion of Dr. Corcoran, taken by consent.**

Knox County—one member, financial hardship because of illness, **on motion of Drs. Edwards and Paris.**

Jackson County—one member, retired because of ill health, **on motion of Dr. Black, taken by consent.**

Marion County—two members, both retired because of illness, **on motion of Dr. Donato, taken by consent.**

Delaware County—One member, for 1963, injured in an accident, and delinquent in payment of 1963 dues, (Senior member in 1964). **1963 dues remitted on motion of Drs. Taylor and Paris.**

Tippecanoe County—one member, retired due to illness, **on motion duly made and taken by consent.**

Lake County—two members, one, financial hardship because of illness, and the other retired, **on motion of Drs. Steen and Paris.**

Allen County—one member, retired and ill, **on motion of Drs. Popp and Paris.**

2. *Expulsion of member.* The question of a refund of state dues paid by a member who was expelled on April 14, 1964, from membership in his county medical society was discussed by several and **on motion of Dr. Steen, seconded by many, the Council voted that the state dues shall be refunded on a pro rata basis,** which means that two-thirds of the physician's payment for 1964 state dues will be refunded.

3. *Nominations of two members for Editorial Board.* **On motion of Drs. Paris and Popp, Drs. Harold D. Lynch, Evansville, and Jene R. Bennett, South Bend, were nominated to succeed themselves; the nominations were closed, and the unanimous ballot of the Council was cast for Drs. Lynch and Bennett.**

4. *Blue Shield Board of Directors.* The chairman of the Council reminded councilors of Districts 1, 5, 8, 9 and 12 that their districts should nominate this year one member each for the Blue Shield Board of Directors, for the three-year term beginning March, 1965.

5. *Nomination of one Blue Shield Board Member-at-large,* to replace one member whose term will expire in March, 1965, was deferred until the October meeting of the Council.

6. *Member for Blue Cross Board of Directors.* Mr. Guy W. Spring, executive director of Blue Cross Hospital Service, read a letter which he had sent on April 24, 1964, to Dr. Neumann, concerning a vacancy on the Blue Cross Board caused by the resignation of Dr. Murray DeArmond and requesting the Council to nominate a replacement.

On motion of Dr. Paris, seconded by many, Dr. Eugene S. Rifner was nominated for membership on the Blue Cross Board of Directors.

Mr. Spring announced that beginning July 1, 1964, an increase in rates for direct-pay members will go into effect. This is the first increase in two years for this particular group.

7. *Nomination of Council liaison representative* of the Indiana State Medical Association to sit with the Board of Directors and Medical Advisory Committee of Blue Cross to replace Dr. Rifner was deferred until the next meeting of the Council.

8. *Recommendation of Commission on Medical Economics and Insurance* that "a psychiatrist be appointed to the Blue Shield Board as soon as possible because of increased interest in insurance coverage for psychiatric illness" was brought to the attention of the Council.

Matters from Committees and Commissions

1. *Student Loan Committee.* In the absence of Dr. Lester D. Bibler, chairman, the chairman of the Council discussed the financial statement of the Student Loan Fund, pointing out that $20,810.00 is on deposit with the Indiana National Bank to guarantee loans to students under the new program, which makes more than $250,000.00 available for loans at this time. Loans totaling $6,800.00 have been granted since the plan with the bank was inaugurated.

The agreement between the bank and the association was reviewed again, the chairman stating that this agreement had been ratified by the Student Loan Committee, after careful study by the legal counsel for the association, and it fully protects the state medical association.

2. *Council Liaison Committee with Blue Shield.* Dr. Steen, chairman, reported:

a. Blue Shield had officially rescinded the previous election of a board member and then elected a member to the Board of Directors of Blue Shield in accordance with the wishes of the Council.

b. A large amount of correspondence between members of the Council Liaison Committee and the various officers of Blue Shield will finally result in some reconciliation of opinions about certain matters.

c. Board members, as a result of the recent public relations meeting, are invited to suggest items to be put on the agenda for Blue Shield Board of Directors' meetings.

d. Survey to be made by National Association of Blue Shield Plans in which all Indiana physicians will be circularized. Blue Shield asks the Council to lend its support in getting cooperation from the physicians in assembling information needed for these plans.

e. National Blue Shield had negotiated a contract with federal employees for a full service plan.

f. Blue Shield is asking that the Council again take a look at resolution No. 26 and see how this can best be implemented so as not to lose approximately 100,000 federal employees in Indiana who will otherwise not be able to be enrolled by Blue Shield.

MR. RICHARD C. KILBORN, assistant executive vice-president of Blue Cross-Blue Shield, in answer to Dr. Edwards question as to what type of survey the National Association of Blue Shield proposed to make, said: "Actually, Indiana is just one of the states that will be surveyed. It will be a national survey of all Blue Shield plans throughout the country. The association has already made a test survey in two states. The idea, of course, is many of our national employers are asking us to tell them what kind of a job our different programs will do. This is one way to show the national employers just what kind of performance our respective programs do throughout the country.

"The survey itself will test the standard schedule, the preferred schedule and the county programs throughout the state. The answers to the survey, or the questionnaires themselves, will actually be sent to Chicago. The tabulation on the survey will be made in Chicago rather than locally. The questionnaires will be sent from our office in Indianapolis on a sample basis, to the physicians in Indiana and from there to Chicago.

"The survey will deal with fees and services, etc. The questionnaire has about ten questions on it that can be answered, 'yes' and 'no' dealing with the doctor's type of practice, how long he has been in practice, and things like that. Of course, the main question on it is, 'what was your charge to your patient and what did you receive from Blue Shield toward that payment.' It takes less than a minute to fill out the entire questionnaire. We hope that no doctor will receive more than five. Some doctors won't receive any, some will receive one or two. A few doctors may receive more than five. Since the survey is on a random sample basis, the doctors who send us a great number of claims probably will get a few more questionnaires than the ones who just send us a few The questionnaire in each case will be identical, but on different patients This will not be a general survey, it will be on each patient. We will go through the claims we receive from physicians, and, on a sample basis, pick one out of every

ten or twenty claims, and we will send a questionnaire on each one of these claims We think the survey will give us an opportunity to measure our own performance on what we're paying for, let's say, internal medicine versus the performance we're doing on surgery, and it may give us some guide as to how we can develop our programs a little better in the future.

Resolution No. 26. At the request of the chairman of the Council, Mr. Kilborn discussed resolution No. 26. "Since resolution No. 26 was passed some time ago we have had quite a bit of experience to talk about. At the present time we have three major employers covered statewide, General Motors, Ford and Chrysler. We also have some other counties set up on special programs. I have some IBM figures here that show from April, 1963, to March, 1964, a total of 148,954 claims went through our office under these programs. The total dollar volume involved was $5,215,590.00 during that same period. The interesting fact to me, which I think attests to the success of the program and the cooperation of the physicians throughout the state of Indiana, is that out of almost 150,000 claims that went through over the one-year period, we actually had only about 100 claim problems of varying degrees. To me this pretty well confirms the fact that Resolution No. 26 did set up a mechanism which not only could work, but *does* work in Indiana. One of the speakers at our special conference for delegates of the hospitals this last weekend testified to the fact that they are very satisfied—from the General Motors standpoint—with the way resolution No. 26 is working in Indiana."

Mr. Kilborn presented for perusal of the councilors the Blue Shield Test of Performance report for 1963, breaking down the performance into the standard schedule, the preferred schedule and the General Motors contracts. "Again the Motors program shows that we are paying 91% of the bills in full under the Motors and the county programs —with which we and General Motors are very pleased Federal employees in many parts of the country are covered under service contracts, and with Blue Shield indemnity plans. The head of the Civil Service Commission of the federal government came to the National Association of Blue Shield plans and requested that the service plans raise their family income ceiling to $7,500 throughout the country, and that the indemnity plans seriously consider an approach similar to resolution No. 26 for federal employees throughout the country."

On motion duly made and seconded, the Council agreed that "resolution 26 adequately covers this program and we may go ahead and implement it."

3. *1964 Annual Convention, Indianapolis, October 12 to 15, 1964.* DR. CHARLES FISCH, chairman of the Commission on Convention Arrangements, reviewed the annual convention program which, he reported, was essentially the same at this time as had been presented to the Council at the January meeting. Inasmuch as the commission decided that the general scientific program is to be composed of guest speakers who appear on the section programs, and only three sections have sent their programs to Dr. Fisch, the final draft of the general scientific meetings is not yet complete. Dr. Fisch asked the councilors to urge the section officers to forward their section programs to him. **By consent the Council approved the program as presented with the final program to be presented to the Council at the July meeting.**

4. *1965 Annual Convention, Indianapolis, October 12, 13 and 14, 1965.* Dr. E. S. Jones called attention of the Council to the fact that the Council on Occupational Health of the AMA would meet jointly with the Indiana State Medical Association in October, 1965, and asked that the councilors do all they can to get every member of the state medical association to attend that meeting.

5. *Legislative report.* In the absence of Dr. Eugene Senseny, chairman of the Commission on Legislation, the chairman of the Council read the following report:

"The Commission on Legislation is concerned at this time with making the Kerr-Mills Law effective in Indiana. Although this has been handled on a higher level, it is the feeling of the commission that the Indiana State Medical Association should help in augmenting this type of effort.

A meeting of this commission will be called late in May or early June to discuss not only this problem but also those occurring in January, 1965. Some of the pertinent things to be discussed are listed below:

(1) Legislation regarding the 'battered child syndrome.'
(2) Is the Good Samaritan Law, which we already have, good legislation?
(3) Blood service laws.
(4) A privileged information law.
(5) A bill to allow chiropractors legally to care for Workmen's Compensation patients.

The pediatricians and pathologists have been asked to look into the battered child syndrome legislation, blood service laws, and the privileged information laws, such as exist in Iowa.

On all of these matters the AMA's legal counsel has been sought in the past, and should be used again.

Two other problems should be mentioned:

(1) Podiatrists would be compensated under the Kerr-Mills Law, and
(2) Currently pending in southern Indiana is a half-million dollar lawsuit by a chiropractor who is being denied hospital privileges."

6. *Areawide Planning of Facilities for Rehabilitation Services.* The action of the Commission on Public Health in approving Dr. Offutt's report on this subject was brought to the attention of the Council. **By consent, this report is to be circulated to the members of the Council in order that it may be discussed at the July meeting of the Council.**

7. *Discussion of the recommendation of the Commission on Aging* that medical students be exposed

at least once a year to a lecture on gerontology was deferred until the July Council meeting.

Reports of Guests

1. *Medical education needs in Indiana.* Dr. J. Lawrence Wilsey, vice-president, and Mr. Rockwell Schulz of Booz, Allen & Hamilton, Inc., Chicago, presented statistics on the availability of and the need for physicians in Indiana, the development of medical education in Indiana up to the present time and future Indiana medical education needs.

An outline of the 13 criteria and seven alternative courses of action that might be followed in meeting future medical education needs in Indiana was distributed to the Council for study and consideration. Councilors were asked to send their comments to the headquarters office, these in turn to be forwarded to Booz, Allen & Hamilton.

2. *Tuberculosis eradication program.* In the absence of Dr. A. C. Offutt, state health commissioner, the chairman announced that the Council had approved by mail the tuberculosis eradication program. He also called attention to the letter received from Dr. Paul D. Crimm regarding this program, a copy of which had been given to each councilor.

3. DR. DENNIS S. MEGENHARDT, member of the Blue Cross Professional Advisory Committee, reported that liaison between Blue Cross and the association was improving month by month.

4. DR. JOHN I. NURNBERGER, *acting dean, I. U. School of Medicine,* addressed the Council on problems facing the school, namely, shortage of teaching faculty, shortage of clinical facilities in the I. U. teaching hospitals, and the need for financial help for Long Hospital and the proposed new University hospital. "Substantial support must come from Hill-Burton funds. We will not be able to take all of the students now enrolled in the first and second years and give them clinical supervision in our current clinical facilities." In this connection, Dr. Nurnberger suggested that the Council submit a query to Dr. Offutt as to what can be done to explore the balance between local community needs and the total needs of the state for medical education.

Dr. Nurnberger also spoke of the shortage of internship and residency positions in the state, which contributes to the loss of physicians in Indiana. "This state needs vastly expanded internship facilities and that means training supervisory staffs and assisting in the development of programs for internships, as well as residencies. So it seems premature to extinguish, in a sense, the third and fourth years of adequate clinical training in our medical school in order to develop plans for a second medical school. These problems must be approached in some sort of a systematic and orderly way. We should do whatever is necessary to continue at a more optimal level—maximum medical education in our own facility before we consider others. First things first."

Dr. Nurnberger told of the establishment of a computing center on the Indianapolis campus—one of the 15 or 16 in medical schools in the country—to provide the most modern type of computing facilities for data processing and for the development of new technics. "This is a solid reflection of national recognition of our scientific personnel, especially Dr. James Norton, since all of the funds had to clear through experts in this field. This is not a gift from anybody."

On motion of Dr. Edwards, seconded by many, the Council went on record urging the committee for Hill-Burton funds and the State Board of Health to reconsider and provide necessary financial support this year for the Indiana University hospital expansion program. The secretary was directed to present this viewpoint to Dr. Offutt and his committee.

Preceptorships. This plan for development of general practitioner preceptorships was reviewed. Dr. Nurnberger reported that he had been informed that the plan had been approved and the only thing that was left unspecified was the working machinery for naming, approving and working with preceptors around the state. This matter had been referred to Dr. Francis Land since he is a member of the AMA Council on Medical Education. To date the plan has not been implemented. **On motion of Drs. Paris and Edwards, the Council approved the preceptorship program, with the presumption that Dr. Land and the Liaison Committee with the Medical School will get together and set up criteria for establishing preceptorships.**

5. *Blue Shield-Blue Cross program for state medical association.* MR. LLOYD J. BANKS, director of Enrollment Division, Blue Cross-Blue Shield, distributed to the Council the annual report on the Blue Cross-Blue Shield plan for members of the state medical association, containing figures explaining the reasons for the increase in rates for this coverage. Mr. Banks said, "We are establishing four (4) sales areas and a suitable sales staff to work directly with the physicians as well as the dentists and attorneys. Since the health care plans for professional men and their families vary considerably from those found in industry, we deemed it advisable to provide such a service. Our salesmen will be available to the physician for personal counsel relative to his own needs for adequate hospital-surgical-medical benefits. We would like at this time to obtain your approval to pursue this effort further and we will report to you at the end of the year our findings and evaluations."

Following discussion and questions by several councilors, the chairman of the Council announced that the Council had approved this program by mail ballot.

Date for Summer Meeting

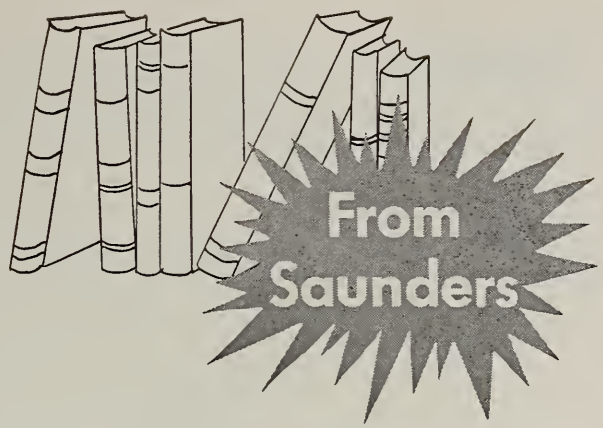
July 19, 1964, was selected for the next meeting of the Council.

There being no further business, the meeting was adjourned. ◄

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EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced with margins af one inch.

Phatagraphs shauld be printed on glossy paper. Negatives cannat be used.

Illustrations are desirable. Selectian of illustrations submitted at discretian of editor and editarial board members. Cast af calar illustratians must be shared by the authar.

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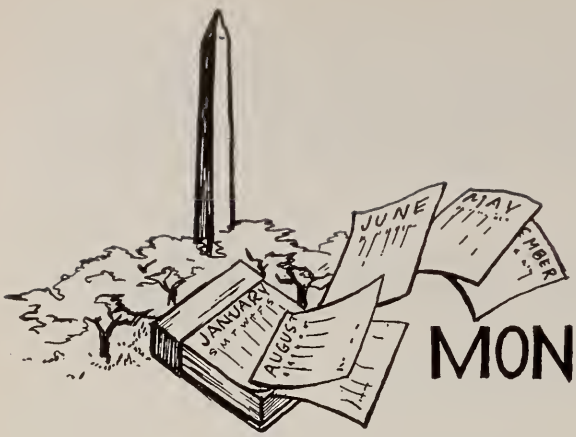
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This summary of what is happening in Washington is prepared by A.M.A.'s Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

MONTH IN WASHINGTON

WASHINGTON, D. C.—The House Ways and Means Committee handed the administration a defeat by refusing to act this year on the controversial King-Anderson plan for a compulsory Social Security hospital-medical program for the aged.

However, King-Anderson supporters expressed the hope the Senate would add the proposal to a flat Social Security cash benefit and tax increase bill adopted by the Ways and Means panel.

Rep. Cecil King (D., Calif.), a committee member and a sponsor of the King-Anderson bill, conceded the bill did not have enough votes to pass in committee. "I don't ever want to have an adverse vote," he told reporters.

In addition to blocking King-Anderson, the Ways and Means Committee decided to take no action on proposed changes in the Kerr-Mills program of federal aid to states for health care benefits for the elderly who need financial assistance to pay hospital and medical bills.

The five percent boost in the current maximum $127 monthly payment for retired Social Security beneficiaries would be the first Social Security cash increase in six years. It is designed to keep the pension payments abreast of the cost of living. The increased benefit would be financed by a tax rise that, in addition to already slated tax boosts, would bring the Social Security levy by 1971 to 4.8% paid by both worker and employer on the first $5,400 of salary. Present tax is 3.625% on $4,800. The benefits would add up to an extra $1 billion a year.

The first motion before the committee was to increase benefits by six percent, but Rep. King urged the King-Anderson supporters on the Democratic side of the panel to oppose this on grounds it would bring the Social Security tax so high it would be difficult to attach King-Anderson and even higher taxes to Social Security.

Other Social Security changes in the legislation would:

Extend Social Security to an estimated 150,000 self-employed physicians.

Allow widows to receive benefits at age 60 instead of 62 with a slight cut in payments.

Continue payments to widows with dependent children in school until the children reach age 22 instead of 18.

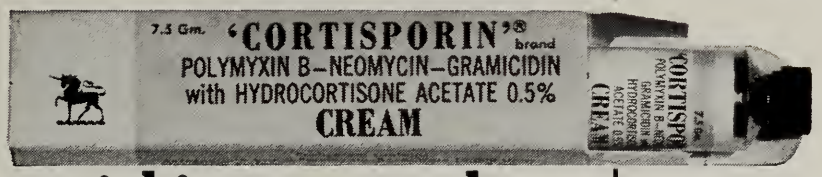
Commenting on the Ways and Means action, Dr. Norman A. Welch, president of the American Medical Association, declared the committee "acted wisely and responsibly" in refusing to approve the King-Anderson bill.

In a statement, he declared:

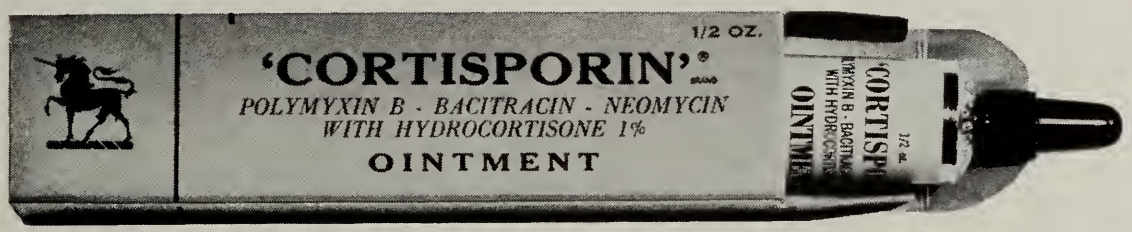
"We are confident that this decision is in keeping with the attitude of the majority of the American people toward this legislation, as reflected

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in numerous surveys by members of Congress and by private opinion sampling organizations."

Dr. Welch said, "we have opposed King-Anderson legislation because it would force heavy payroll tax increases on the nation's workers and their employers to provide hospitalization benefits indiscriminately to all the elderly, the wealthy and the well-to-do included."

DRUG INDUSTRY CHALLENGES FDA REGULATION IN COURT

The drug industry decided to challenge in court the controversial Food and Drug Administration regulation requiring drug makers to produce proof of efficacy for virtually all new drugs approved since 1938, in addition to other provisions.

The industry has argued that Congress intended for the law to apply only to new drugs since enactment of the legislation. The FDA asserted that "what Congress intended was a comprehensive review of all drugs now on the market as a result of new drug clearance."

AMA RECOMMENDS CIVILIAN PHYSICIANS TREAT RETIRED MILITARY PERSONNEL

The American Medical Association recommended that retired military personnel receive health care benefits under a contributory private health insurance plan similar to that now in operation for civilian federal workers.

Dr. Reuben A. Benson, chairman of the AMA Council on National Security, told a House Armed Services Subcommittee that by 1980 it is estimated that the number of retired military will reach 4,397,000. "Any health care program devised or conceived must be sufficiently elastic and effective to adjust to these demands," he noted.

He said the AMA recommends the adoption of a plan patterned after the Federal Employees Health Benefits Program. "It is the AMA's opinion that to the maximum extent possible, this care should be provided by civilian physicians in civilian facilities," Dr. Benson testified. "The association, however, recognizes that the retiree and his dependents may be authorized the use of military facilities but recommends that such use be limited to present military facilities on a space-available basis."

AMA ASKS CONGRESS TO REJECT CHIROPRACTIC PROPOSALS

The American Medical Association asked Congress to reject proposals that would reimburse qualified federal workers for chiropractic treatment under the Federal Employees Compensation Act.

In a letter to a Senate Labor Subcommittee, Dr. F. J. L. Blasingame, AMA executive vice-president, declared that chiropractic is not based on sound scientific principles. ◄



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LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

I, Too, Am Diminished

Frank Morriss

I write this neither to uphold or condemn the doctors' strike in Belgium. The issues in such a situation are so complex that a clear-cut defense or condemnation cannot be made.

I write to remind those who care to listen that the medical profession is an ancient and free one. It is nearly as ancient as priesthood, and, in fact, in some areas seems to melt in origin into that profession. It is absolutely necessary that it remain a free profession itself. It is dictated by the nature of the profession and by the welfare of the recipients of its services. Whether doctors in Belgium used proper methods to attempt to remain free is beside the point entirely. The point is, that in struggling to remain free, they are struggling for every other profession (including the priesthood, if we may here call such a profession). Their struggle, in the long run, is actually in behalf of their patients as much as in behalf of themselves.

But the prime interest of most physicians and dentists is that they remain free because only in remaining free can they function properly in their profession. Pope John himself clearly recognized that the fulfillment of responsibilities of men demands that they remain free in the exercise of those responsibilities.

For a doctor to allow anything extraneous to his own conscience and skill to dictate to him how to function as a doctor would be as immoral as for a writer to allow anything beyond his own conscientious beliefs to dictate to him what to put down as truth.

When he is not allowed to function freely as a doctor, the door is opened to the most dark and disgusting immoral chambers. Those physicians who allowed the Nazi regime to dictate to them in matters of medicine degraded themselves and their profession. If the government has the power to insist he abide by his oath, it also has the power to insist he break that oath. That, in fact, is what totalitarian regimes almost inevitably do demand.

I am not saying, mind you, that doctors or any others should be above laws for protection of the common good. I am saying that the professionals must be beyond the dictation of the government in the exercise of their professions.

Those in Belgium, Canada, the United States, or any other country who are tempted by the offer held out by socialists to control medicine should think twice as to what it would mean.

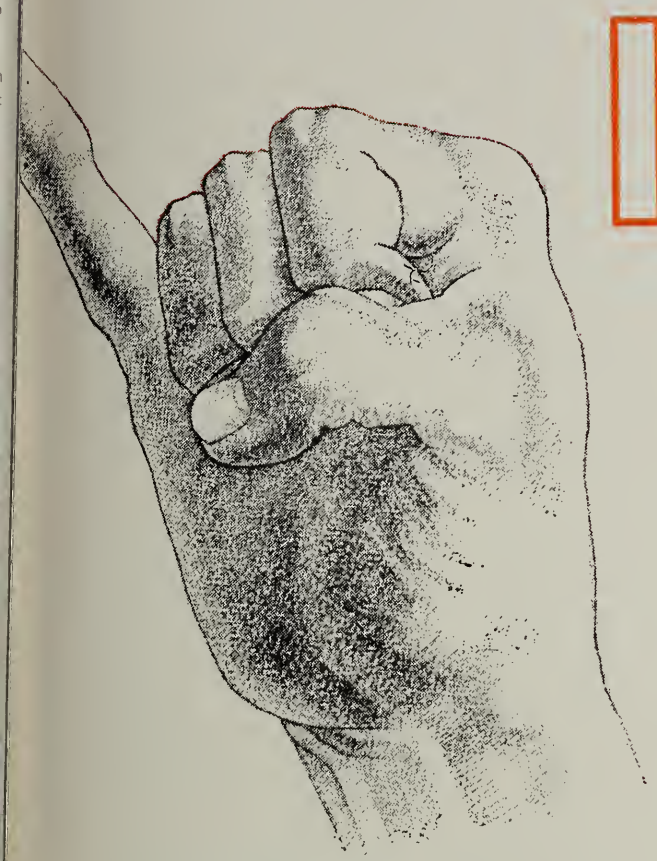
It would mean that a third party has entered into the relationship between the doctor and the patient. That party (and with recent revelations about government methods of snooping this is a very real danger) would in a sense be present at every consultation, and would have at least a potential voice in every decision.

The records of the relationship between patient and doctor would no longer be under the complete control of the physician. Those aspects of individuals' lives which are—next to the matters of conscience entrusted to priest and minister—the most intimate and secret would be open to the eyes of the omnipresent bureaucrat.

As the doctor became more and more the

Continued on page 844.

arthritic joints from



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gouty arthritis, rheumatoid spondylitis, osteoarthritis, bursitis, fibrositis, and neuritis. Arthralgen may be used for analgesia in colds, flu, and various myalgias.

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SUPPLY: Arthralgen (white, scored) and Arthralgen-PR (yellow, scored) tablets are available in bottles of 100 and 500.

*Cohen, et al: J.A.M.A., 165:225, 1957.

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Continued from page 840.

tool of that bureaucracy (remember, the Belgium strike was precipitated by an *extension* of medical benefits, the social security law, an extension similar to the ones the government here says would never be asked for), efficiency would inevitably suffer.

Those of other professions, trades, and skills may stand by unconcerned while this tragedy takes place. But they should take heed from the words of the poet and preacher John Donne. The bell that tolls the death of free medicine is also tolling the death of free religion, free justice, free press. All the excuses of the common good that apply to medicine apply in different degrees to these other professions.

My only link to the medical profession is that I am a free patron of its services, and that I practice, too, an ancient free profession as a practitioner of true words and opinions.

What diminishes the freedom of my doctor takes from me, too.—*The Register*, (Southwestern Indiana Edition) April 24, 1964.

For Life On The Open Road

Sweeping superhighways are not an unmixed blessing. The pair of spectacular chain-reaction accidents south of Lafayette Sunday illustrated the point.

The two series of accidents occured on a good, four-lane divided highway. It's the kind of road on which you can zip along easily, even in fairly heavy traffic. That's how trouble begins.

The chain-reaction pile-up, often involving actually dozens of vehicles, has become a common hazard on heavily traveled multiple-lane roads, particularly in the areas of the big cities of the East and West coasts.

They are caused by drivers who think they can drive 60 miles an hour by the same rules they use at 25 or 30. And a lot of them are already using bad rules even at city street speeds.

The chief blunder is following too closely. You can observe this error in action any weekday morning or afternoon rush hour on any of the city's traffic arteries. It is especially obvious on the one-way streets. Cars run in packs, almost bumper to bumper. Lane-jockeys, alert for chances to improve their position, close the gaps even tighter.

The running seems smooth enough as long as all goes well. But when someone up ahead makes an unexpected stop, there's lots of tire screeching and once in a while some metal crunching.

The modern divided highway very much resembles a pair of one-way streets. The packs of cars run at twice the speed, or more. The intervals between cars, already too short in the city street packs, do not open up in proportion to the increase in speed. The result is a constant invitation to disaster, if something goes wrong.

The thing that goes wrong is the unexpected, of course. Often it's a patch of fog, or smoke. It may be a driver signalling too late, or not at all, before a turn. It may be an animal suddenly appearing on the roadway, a blown tire, a stone or a hole in the pavement. On the Lafayette road Sunday, capricious snow squalls provided the triggering action.

There's a hard way and there's an easy way to learn safety habits that can save your life—or the other fellow's—on the open road. The easy way is to cultivate safe habits. One of the essential ones is that of leaving room in front of your nose for the unexpected. We recommend it highly.—*Indianapolis Star*, March 31, 1964.

Doctors In A New Light

It would be profitable to do a little ruminative thinking about the rather weird goings-on in the doctors' strike in Belgium.

Belgium has a new national health insurance program. Among other things the law sets uniform fees for the services of physicians. The doctors protested the fixed-fee system on the ground that it is destructive of individual relationship between patient and doctor.

It seems almost unbelievable that doctors, whatever their grievance, would go on strike. Doctors just don't do things like that. There's the Hippocratic oath, and all

that. The doctor is the only one who has the knowledge and skill to save life and ease suffering through medical science. It's taken for granted that he is therefore a special kind of person, dedicated to the service that he alone can perform.

Well, if that's what we expect doctors to be like, we have to treat them like that kind of people.

When you put the doctor on a schedule of fees fixed by law, you put him in a different role. You put him in the category of retail clerks or appliance repairmen. We aim no aspersions at clerks and repairmen. The point simply is that they operate on a commercial basis and that is what is expected. No one is shocked if they go on strike.

Medical programs with legally fixed fees put doctors on a commercial basis. In that case, why shouldn't we expect a commercial reaction?

From workers demonstrating against the strike came a charge that the striking Belgian doctors were "assessing human lives in terms of money." Isn't that just exactly what the health program law did?

Such thoughts as these should be turned over and over again by Americans as Congress ponders the issue of a national medical insurance program. There is great humanitarian appeal in the idea of calling on the Federal taxing power for the resources to take care of the health needs of the elderly. But where do you draw the line between this approach and "assessing human lives in terms of money?"—*Indianapolis Star*, April 8, 1964. ◄

About Our Cover

A lonely, unhappy child . . . unable to understand why he is ostracized and treated like an "ugly duckling."

What despair he must feel when he runs up against a blank wall of fear and misunderstanding — just because he is an epileptic.

Most Americans still have only a shadowy idea of what epilepsy is. And unfortunately we usually repel anything we do not understand. So strong is the stigma attached to epilepsy that many states still carry on their books (and sometimes enforce) astonishingly barbaric laws.

Distressing as this is, the victim of epilepsy suffers more from ignorance, fear and downright hostility. The moment he suffers an attack in public or speaks openly of his disorder, people shun and avoid him like the leper.

The term "epilepsy" has probably been spoken and written about more often during the past few months than at any other time in our history. And the Jack Ruby trial in Dallas only added to the prejudice and superstition.

With the development of increasingly effective drugs and more advanced surgical technics, physicians can control epilepsy as effectively as they control diabetes. And yet the basic problem still remains — getting *people* to understand what epilepsy is and remove the fears and hostility which surround it.

Physicians aid daily in the battle toward an enlightened public. They help to quell the fears and apprehensions of the child and his family, and also minimize any emotional difficulties which may develop.

Understanding and support from both parents and physicians, coupled with an informed and comprehending public, can definitely lead to reassurance and hope for the epileptic.

The Journal would like to thank the Epilepsy Foundation for allowing us to use their symbol on this month's cover. The Foundation is currently campaigning to dispel the myths and hostility that have made their drawing meaningful.—J.F.S.



thrown for a loss...

Keeping flies out of pharmaceutical production areas is important, yet entrances must accommodate heavy traffic of people and materials. In fact, at Eli Lilly and Company, the entrances to certain production facilities where traffic is heaviest have no screens or doors. □ This makes it look easy for flies to get in. But let one try it and he is literally picked up by a fast-moving blast of air and thrown for a loss—back outside. This "curtain of air," moving down and out from the top of the open doorway, bars the entrance and keeps flies out . . . still another step demonstrating the care that goes into the finished product.

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The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Supervised by THE COUNCIL

Volume 57 — August 1964 — Number 8

Surgical Prospects for Today's Diabetics*

CHARLES M. CLARK, Jr., M.D. †
Indianapolis

THE WELL-CONTROLLED diabetic patient of today is able to undergo major surgical procedures with little more risk than his normal counterpart. Diabetic mortality ranged between 1.5% and 2.5% in a recent series.[1] When this is compared with the 25% mortality prevalent when Joslin wrote his first book on diabetes just 45 years ago, it is an astonishing documentation of advances in the metabolic management of the surgical patient. No patient today should be deprived of a surgical procedure simply because he is a diabetic!

To obtain and maintain this low mortality, it is necessary to be aware of the problems peculiar to the diabetic and his management. At the onset, it is of primary importance that the surgeon know that his patient *is* a diabetic.

There is steadily increasing evidence that the asymptomatic diabetic has increased morbidity and mortality years before his diabetes becomes manifest. A recent survey by the Indianapolis Diabetes Association uncovered 547 diabetics and 200 probable diabetics in 16,000 persons screened.[2] This correlates closely with the national average of two percent undiscovered diabetics in an unselected population.[3] Therefore, as part of the routine preoperative workup, a careful family history and postprandial blood sugar should be taken. The postprandial value is much preferred since it will be abnormal more consistently in the early diabetic. In fact, half of known diabetics have a normal fasting blood sugar.

Once it is decided that a diabetic patient needs surgery, the surgeon should undertake a careful review of the patient's medical history, paying particular attention to the renal and cardiovascular systems. He should be careful to ask about drugs; many diabetics are hypertensive and are therefore taking potent agents such as rauwolfia. Another common drug to watch for is chlorothiazide and its co-genders which may cause hypokalemia.

Laboratory work on the diabetic should include a fasting and 4 p.m. blood sugar, CBC, urinalysis, BUN, and an electrocardiogram and chest films if the patient is an adult. The CBC reflects the patient's nutritional state; the urinalysis and BUN may reveal asymptomatic renal disease; the EKG is necessary both to provide evidence as to the diabetic's cardiac status and to provide a baseline if any question of myocardial disease should arise postoperatively. The renal and cardiovascular diseases make up two-thirds of the diabetic triopathy; the third, retinopathy, should be carefully looked for on physical examination.

It is not the abnormalities in carbohy-

* Presented before the Indiana Chapter of the American College of Surgeons clinical meeting, April 11, 1964. Recipient of the Gatch Award.

† Intern, St. Vincent's Hospital.

drate metabolism but the deadly renal and cardiovascular diseases which kill today's diabetic. In Joslin's series of over 5,000 diabetics, three-quarters of them died from vascular diseases while only one percent died from coma. [3] It is axiomatic, therefore, that an accurate evaluation of the diabetic's renal and cardiovascular status is imperative to his evaluation as a surgical risk.

Preoperative Control

After admission, the physician must assure himself that his patient is in good control prior to surgery. About 80% of diabetics can be controlled on diet alone or on diet and oral hypoglycemic agents under ordinary circumstances. [3] However, all patients on oral agents should be changed to insulin before being subjected to the stress of surgery. This is necessary because of the impaired gastrointestinal function which follows surgery and, more importantly, because insulin is necessary for protein synthesis and, thus, good wound healing.

When changing from an oral agent to insulin, one should start with 10-20 units of long-acting insulin and adjust according to blood sugars. Acetohexamide and tolbutamide can be stopped and insulin started in 24-36 hours, but it takes two or three days to change from the longer-acting chlorpropamide. The degree of control obtained prior to surgery will depend upon the urgency of the situation and the liability of the particular patient's diabetes.

Given elective surgery, control with a fasting blood sugar of 110 mg. per 100 ml. and a 4 p.m. blood sugar of 150 mg. per 100 ml. is ideal and obtainable in about 95% of diabetics. [3] Achievement of this control prior to surgery will smooth the postoperative course and lessen complications.

The objectives of diabetic management during surgery and the postoperative period include those of any surgical patient, that is, to promote wound healing and to reinstitute normal physiologic function as rapidly as possible. The diabetic presents additional problems in that his metabolic needs require more manipulation. One must supply enough exogenous insulin and carbohydrate to meet the patient's basal energy requirements while preventing the extremes of ketosis and hypoglycemia. In addition, enough fluids and electrolytes must be provided to maintain the body's internal milieu and to replace losses from drainage and emesis. The best method for accomplishing this is by oral feeding which should be reinstituted as soon as possible after surgery.

In the interim, this obviously complicated task cannot entirely be set to formulae; every case will have its unique aspects which makes medicine the art that it is. Yet certain guidelines have been determined. It is known that the adult needs 2,000-2,500 ml. of water each day for maintenance. In addition he needs 75 meq of sodium and 50 meq each of chloride and potassium. [4] Finally, he needs a minimum of 100-150 gms. of carbohydrate to prevent the body from utilizing its protein for energy. The diabetic with his impaired renal function and carbohydrate metabolism presents an even more complex picture.

This discussion will be limited to the unique problems of the diabetic, and I refer you to Dr. W. Segar's excellent monograph for a discussion of electrolyte balance. [4] The method to be discussed is the one devised by the Lahey Clinic. [5] On the morning of surgery, the patient receives his usual dose of insulin including long-acting insulin. An intravenous infusion of five percent dextrose is started and the rate adjusted to 250 ml/hr. This infusion is continued until surgery is completed. In this manner the patient is protected from hypoglycemia yet surgery does not have to be scheduled in the morning. After surgery, the patient's fluid and blood losses are replaced. A minimum of 3000 ml. is given over a 12 hour period.

Postoperative Control

Each day thereafter a fasting blood sugar is obtained, and insulin dosage is adjusted according to the following schedule:

Fasting Blood Sugar	Morning Insulin	4 p.m. Insulin
130-150 mg%	same	none
below 130	less 10-15 units of long-acting *	none
150-180	plus 10-15 units of long-acting *	10 regular
above 180	same	same and 10 units long-acting *

* Lente or NPH insulin.

Fluids are given to a total of 3000 ml. per day over a 12 hour period in two infusions, one beginning at 8-9 a.m.; the other at 3-4 p.m. This is given as a five percent dextrose solution with the proper electrolytes added. These fluids provide the 150 gms. of carbohydrate necessary to inhibit protein catabolism and starvation ketosis, simulate the normal carbohydrate intake and prevent hypoglycemia. The method alleviates the need for "covering" urine sugars and ketones and allows the patient to be free of encumbering tubing while sleeping. If the diabetes seems to be getting out of control, blood ketones, CO_2 and pH should be used to guide further insulin administration.

It should be remembered that certain surgical procedures (such as drainage of pus, amputation of a gangrenous extremity, adrenal or hypophyseal removal) *a priori* lower insulin requirements and that insulin should be reduced accordingly.

Certain complications tend to arise in the diabetic and should be diligently searched for. Neurogenic bladder, infection of the wound or urinary tract and myocardial infarction are particularly common. Because of the real danger of myocardial infarction in the diabetic while he is anesthetized, a postoperative EKG should be almost routine. If the patient's insulin requirements start to increase, a source of infection should be searched for.

In summation, the diabetic patient is a good risk provided the surgeon assures himself of good preoperative evaluation and control, provides adequate insulin and glucose during recovery, suspects complications and treats them vigorously. ◄

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Athletics and the Heart*

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WHAT CHARACTER do you think a well known pharmaceutical company used to inform the nation's physicians about their excellent drug for "nervous indigestion?" They used a caricature of a coach named "Poor Linus T. Formation, a coach with many worries."

"We haven't won a game since '60," he moans, "my quarterback has double vision, my fullback is a coward and our line is about as tough as wet toilet paper. Jones, my moronic tackle, has gotten out of condition from studying too much. The alumni are already after my scalp, and we still have to play Alabama, Washington, Georgia Tech and Texas! Whenever I think about that schedule, I feel just like I did right after my gallbladder was removed five years ago."

The advertisement goes on to point out that the doctor's examination reveals nothing organically wrong with Linus and concludes that on-the-job frustrations are causing his "nervous indigestion." Perhaps his transfer to a smaller college or his promotion to athletic director would help. But at any rate, try our medication on this "gassy," belching, bloated, flatulent coach.

Now that we have categorized the coach as a bilious individual, let us first discuss strenuous activity and the heart. Dr. Augustus Thorndike, Chief Surgeon of the Harvard University Athletic Department, has pointed out in his book *Athletic Injuries, Prevention, Diagnosis, Treatment* that "The output of the heart has been estimated at from 4-6 liters or quarts of blood per minute at rest, and this is known to increase during physical exertion to as much as 24 liters per minute. Perhaps a good average output during exercise is 20 liters per minute." One can easily appreciate that pumping 20 quarts of blood per minute represents a good deal of work for the heart. That's also a great deal of blood and brings to mind the comment of a romantic young lover to his girl friend, "I'd give you my heart but who's going to pump all that blood?"

The two factors which influence the output of the heart are the volume output per beat and the pulse rate. The well nourished, well trained, muscular heart of an athlete has a greater output per minute than that of the sedentary individual or weekend athlete. Furthermore, such a well developed heart does not have to beat as fast as that of the untrained individual to produce the same output per minute.

Athletic Heart A "Pumping Piston"

The non-athlete cannot increase his heart output more than 50%, whereas the athlete can increase it over 100% at work. In order to maintain this output per minute, the non-athlete has to increase his pulse rate 100%, while the athlete increases his pulse rate approximately 50%. Thus the efficiency of the heart of the athlete is far greater than that of the "Bottom Sitter." The trained individual's heart empties itself more completely with each beat, is more efficient at slower rates, possesses improved contractile power, sets free more energy, has more durability and is a far more efficient organ. In short, the heart beats less often per minute in the athlete, yet pumps more cardiac output per minute.

One could compare this to the blabbermouth who talks a great deal and says little. The quiet man speaks infrequently, but with telling impact. Thus, the old adage defining a coach as one who will give your heart for his school is not quite accurate.

What is it that enables a Herb Elliott to astound the world with his performances on the track? Or Derek Ibbotson, John

* Presented at the Physicians-Coaches Symposium, Indianapolis, October 24, 1963.

Landy, or Roger Bannister (now a physician) and other great winners of our times? Dr. E. R. Trethwie, reader in physiology at the University of Melbourne concludes on the basis of his study of 10 sub-four minute milers, that these men are propelled by a piston-like heart action. He reported to an Australian Sports Medicine Association Meeting that the heart acts more efficiently when the pumping action is like a piston, driving the muscular contractions up from the apex to the valves. Common to all these exquisitely trained four minute milers was the complete and thorough sweeping of the blood almost totally out of the chamber with the piston-like action pumping from the apex to the base of the heart.

We find that this magnificent organ, if properly trained, can be pushed to great heights of physical glory and that serious forms of breakdown and fatal collapses associated with athletic exercise are rare. When death has occurred, which is rarely, autopsy evidence has indicated that one was not dealing with a normal heart and that the sudden demise invariably resulted from advanced disease of the heart or arteries.

The normal heart is invulnerable to the demands and stresses of intense physical exercise and athletic training. Emphasis is on the word *normal*. This makes it mandatory that the athlete have a pre-season physical examination to rule out congenital and rheumatic heart disease. These are the two major forms of heart disease involving young people. A lesser type of problem, but still one to be considered and discussed later, is inflammation of the heart or myocarditis. (The advisability of athletes having a pre-season physical examination is directed more to the college coaches than to the high school coaches.)

It has been reported that the average college athlete is unlikely to have a routine physical examination after his pre-admission examination, and the pre-admission examination is likely to have been performed by his personal physician, who may not be "particularly oriented towards athletics." Often the pre-sports examination is the "once over lightly approach of the harried, hurried, harrassed physician." The athletic department has put too much reliance on this pre-admission examination for too many years, as well as on the chest x-ray which is often, but not always, required just before or after admission to the freshman year. But once it has been determined by a thorough physical examination that the individual has a normal heart, vigorous, intense, concentrated and coordinated training can do no harm.

Watch the Pulse Rate

The basal or resting pulse rate is regarded as an old fashioned but still reliable guide to the value of a training schedule. Many coaches urge that their trainees check their pulse rate on walking each morning. Generally accepted principles of training reveal a slowing of the resting pulse rate, a more rapid recovery to the resting pulse rate after standard exercise, a decrease of the maximum pulse rate brought on by exercise and a marked improvement in the subjective exercise tolerance. In other words, a trained individual has a slow pulse rate at rest, it comes back promptly after exertion and doesn't go as high with exertion. The athlete's subjective tolerance towards exercise also is improved and there is a sense of well-being.

The heart of the well trained athlete beats slower than that of the untrained. Most of the great long distance runners had a resting pulse rate of under 60 beats a minute. Bannister's was 38, and Cunningham's 40. It is reported that Paavo Nurmi's was 42 and both John Landy and Herb Elliott had pulse rates generally around 40. The normal pulse ranges from 60-100 with the average between 70 and 80. A slow beat, a strong beat, an efficient beat . . . this is the simple hallmark of an organ brought up to peak efficiency and conditioning by a thoughtful, prolonged and carefully carried out program of training.

Is there such a thing as an "athletic heart?" This is probably the biggest myth, the biggest farce, the biggest hoax, the greatest perfidy to have been perpetrated on the lay and medical public. There is no such thing as an "athlete's heart or athletic heart." I still have patients who come in and tell me that they have or have had an

"athletic heart." What crass ignorance! In a healthy heart, pathologic changes are not produced by athletics. So, run your boys, train them, pour it to them, because you cannot hurt a normal heart. It can take all that you can dish out.

Other areas will be taxed and tired before the heart is. Remember that this is the heart that runs the 26 mile marathon, produces the less than four minute mile, pulls an oar that drives a boat for miles up a river, and runs up and down the basketball court until it seems it would pound right out of the chest. Some physiologic hypertrophy or enlargement of the heart may occur but this is a normal response, consistent with the rest of the increased body muscle mass. It is not abnormal, it is not a dilated heart, it is not a failing heart and it is not an enfeebled heart.

The only possible entity remotely suggestive of an "athletic heart" is the former great athlete who has become sedentary, corpulent, decadent, paunchy and soft. He then becomes a fit and suitable candidate for degenerative disease of the heart and arteries. Someone knowing of his past athletic record finds enlargement of the heart by x-ray or fluoroscopic examination and calls the condition "the athletic heart." The world is full of former athletes who have become great trenchermen, gluttons and gourmands.

Infection and the Athlete's Heart

After making all of these strong statements about the sturdiness of the normal heart, one caution must be mentioned and should prove valuable to coaches. Following infectious diseases, the circulatory system may react abnormally to the strain of athletics. It is important to bear in mind the transient but nevertheless harmful effects of infection on the heart muscle. These may arise as the result of an infection of the throat, a viral respiratory infection or one of the group of illnesses we designate as influenza.

It is in this area that you coaches come under the greatest criticism. Your star athlete gets the "flu bug" and because of the pressures of the big game coming up, the boy is scarcely allowed to get over this viral infection, one that might have caused some involvement of the heart muscle. The *National Observer* recently published an article on school athletics, written anonymously by the mother of three young midwestern athletes. It was reprinted in a medical journal which is sent to all physicians.

"At a recent high school football game in a midwestern city, the star of the team sat on the bench. He was in uniform but wrapped in a blanket. Wracked with coughing, he could not sit upright. The team doctor, a respected physician in private practice, stood near him. At the critical moment the coach beckoned to his star, led him to the sidelines with an arm around his shoulders and sent him onto the field with a confidential smack on the rear. A pass play was called; the star ran out, snagged the ball, made the touchdown and returned to the bench where he resumed his position, shaking with coughing, head down between his knees, awaiting the next call. The boy lived through it."

I would imagine that if the coach or team doctor had checked his resting pulse rate, it would have been quite elevated. I also imagine that after exertion on the field, it would be unduly high and would have remained so for an abnormally long period of time. This simple physical finding, which all of us are easily able to check, may be used as a guide in determining whether a boy with a respiratory infection should play. As previously stated, it is also a rough guide to the success of conditioning.

The blossoming, exploding, burgeoning interest and involvement in sports, combined with the natural concern of the parents, has resulted in you coaches being blamed for another problem. It is said that coaches are often responsible for the great increase in the sale of tranquilizers. The day before an important football game, a player recovering from a bad case of the "flu" heard his mother say to his father "Let's see if the doctor will give us some tranquilizers. If the coach plays Bill, I'll need them; if he sits on the bench, you'll need them; if we lose the game, the coach will need them."

A word of serious warning, please do not play men with respiratory infections, give them time to recuperate and check their pulse rate at rest and again after exercise

as a guide whether or not to play the individual. Drugs given to your star athlete when he is mildly ill or not ill at all will not significantly improve his athletic output. Dr. Ernest Jokl, who spoke to this group several years ago, told the Institute on Scientific Foundations of Physical Education at the University of Wisconsin in discussing ergogenic drugs that, "No case is known of a world record having been established while an athlete was under the influence of a drug. True, many athletes, like patients, are highly suggestible, and anything given them with due ceremony before competition may make them believe it is beneficial."

There are no royal roads to success in competition. The four main features leading to success in physical fitness are: A generous and well-balanced diet, nine hours sleep out of each 24, graduated muscular exercise and the absence of all artificially stimulating drugs.

One of the first signs of overtraining is the inability to sleep. This is partly emotional (subconscious), partly nervous (conscious) and partly physical over-fatique. Drugs should be avoided . . . especially stimulant drugs for the boy whose energy and enthusiasm has been dampened by infection or overtraining. This infection may have affected the heart and episodes of sudden death from myocarditis have resulted.

A 25-year-old track athlete died a few hours after he finished an 18 kilometer race. Post-mortem examination revealed acute inflammation of the heart muscle (myocarditis) due to a gonorrheal infection of the urethra which had been allowed to remain untreated.

Exercise and Longevity

We have discussed the effects of athletics on the heart, the deleterious effects of infection on the heart, and now finally a word about the heart and longevity. Cardiologists are bombarding the public and their patients with the new philosophy of "the fountain of youth." Ponce De Leon traveled about the world in a fruitless search for the key to longevity. Though the millennium has not arrived, if you and I would push back the walls of death, we must exercise in our boyhood, exercise in our youth, exercise in our young manhood, exercise in our middle age and exercise until the angel of death finally calls us home. High school football makes hearty young people. You can't sit three hours on cold concrete, eat a cold hot dog and peanuts and be a weakling.

Clarence De Mar was known as "Mr. Marathon." His life represented practically half a century of running. His 49 years in athletics constituted a saga unequaled in the annals of marathon running in the United States. De Mar was the subject of considerable medical investigation and he figured prominently in *The Journal of Physiology* in 1928. He was again studied in 1963 by Dr. Paul Dudley White, himself now 77, and former President Eisenhower's physician. These studies were done to determine the presence or absence of heart disease.

Many years before, De Mar had been told that he had a weak heart and the question of the presence of a murmur had been raised the year he won his first marathon. Dr. White's studies suggested slight cardiac enlargement. De Mar continued to work until two weeks before his death at the age of 70. He died from cancer of the rectum which had spread throughout his body. At autopsy, the heart weighed 340 grams, the left ventricle was 18 mm. thick and the right ventricle 5 mm. The striking anatomic findings in the heart were the great size of the coronary arteries which were two to three times normal diameter. The amount of sclerosis of the coronary arteries detected on gross and microscopic examination was negligible.

The conclusions were that any enlargement was physiologic, was consistent with his general muscular body build, that his heart weight was not excessive and that his coronary arteries had stretched out and widened to meet the demands of exercise. There was also no evidence of congenital or valvular heart disease. How difficult it would have been for him to have occluded or thrombosed one of these tremendously enlarged coronary arteries. His exercise had invited healthy and compensatory widening of these vessels.

Coaches are particularly prone to give up exercise when their college days are over. They fool themselves that yard work, playing golf and coaching provides them with needed and adequate physical activity. A report in *The Medical Tribune* dated September 16, 1963, indicates that golf as an exercise in middle age is not strenuous enough. Many who play golf often do not carry their own bags; they roll them on wheels or take an electric cart or caddy. Thus they are minimizing the effect of very helpful and very desirable physical activity. It was Westbrook Pegler who said, "Golf was, I should say off-hand, the most useless outdoor game ever devised to waste the time and try the spirit of man."

Mens Sana in Corpore Sano

Several other recommendations might be made, especially since literally thousands of young men are observing you as living testimonies of a right way of life. They are observing your speech, whether it is salted with obscenity; they are observing your waistline, whether it is padded with fat; they are observing your mouth, whether it is sucking in nicotine. They need to see a former athlete who gets with it and does calisthenics with them, whose jowls are not sagging, who has no inner tube around the mid-section, no bulging backside and no flabby fat on the fronts and backs of the thighs. They will be more inspired to keep up their own athletic activity if they see their coach trim, in good shape and young in appearance.

The young men of this nation may be influenced not to smoke if the majority of coaches do not smoke. It is a sad commentary on physicians who preach the gospel of no smoking yet continue to smoke themselves. Evidence is mounting with ever increasing force that smoking is related to longevity. The American Heart Association, the American College of Chest Physicians, The United States Public Health Service, the American Cancer Society—have all categorically stated that there is a significantly increased incidence of coronary artery disease, a significantly increased incidence of lung cancer, and a very significantly increased incidence of bronchitis and pulmonary emphysema in the cigarette smoker.

Smoking "cancerettes," "coffin nails," "cancer sticks,"—the adult form of thumb sucking, the adult form of nail biting, gratification and fixation at the oral zone of Freud, a desire to return to the breast,—is certainly a factor in reducing breathing efficiency in athletes and coaches. A study arising from the Medical College of Virginia indicated a significant downward efficiency in certain pulmonary function studies in comparing the non-smoking and the smoking athlete. The smoking group, despite their youth and despite the fact that some had relatively short smoking histories, revealed a decreased maximum breathing capacity and a tendency towards a decreased one second forced expiratory volume.

The "fountain of youth," the elixir of life, the moral testimony to the young men under your command is to keep physically active for the rest of your life, keep your weight at the norm and avoid the use of nicotine. You will feel better, you will live longer and you will look younger.

Summary

The normal, healthy, human heart is a superb organ which cannot be overtaxed by athletics, and its function can be marvelously improved by training. There is no such thing as an "athletic heart," and the only disease I know of that will cause an "athletic heart" is "rocking chairitis."

One caution for the coach of today is that his young men have careful pre-season physical examinations, then with proper physical training, their hearts can be brought to optimum states of efficiency. Another caution is that a boy with a viral respiratory infection should be sidelined until he has properly recuperated. Remember that the resting and post-exercise pulse rates are guides to this state. Finally, longevity is definitely related to participation in athletics and the coaches and the nation are enjoined to make physical fitness a lifelong dedication. Maintaining a normal weight, keeping the belly flat and the bronchial tubes free from nicotine are part of this commitment.

The heart is a magnificent organ and its durability is unlimited. But it has to be properly trained, not worked when infected, not loaded with an over abundance of blubber, nor allowed to go to sleep before television in a comfortable rocking chair.

1815 N. Capitol Ave., Suite 405
Indianapolis ◄

From *The Journal* 50 Years Ago

. . . I think in many cases we would be wise if we did find out the worries of people. I known that generally you don't ask about those things in your office, but I think it would be better. If you can keep people from worrying, having forebodings and regrets, a great deal more eye trouble will be relieved. Yesterday we heard a good deal about the effect of a weak cylinder, but the loss of a husband—that would be ten times more harmful than a quarter cylinder too much or too little. Psychoneurosis—I believe every ear, nose and throat specialist is not well read unless he studies this great subject that has to do with our mentality. The things that hurt us in this life, that hurt our patients, are not our enemies on the outside; our opinions are our enemies, and our diseases. I have had patients say they could not get a bit of air through the nose, and you find only a dry atrophic catarrh. The trouble was in the head and brain. I know that sometimes subjective symptoms do come from a atrophic catarrh. They don't feel the passage of the oxygen that we do just because the nose is dry. But these patients had a delusion, and that was the thing that really caused the trouble.

I have had patients come into my office in fear and trembling, saying that they were afraid I would say they had consumption because they had a little dropping in the throat, and I told them that even the doctor himself probably has a little dropping in the throat. I believe it should be the purpose of the doctor to shield the patients, to cheer them up and reeducate them. . . . I tell you, a doctor practicing medicine without taking the mentality of the patient into consideration is not a good doctor. . . . Dr. D. W. Stevenson discussing "Local Manifestations in the Ear, Nose and Throat, Associated with Disease of the Nervous System" by Joseph D. Heitger, M.D., *JISMA*, August, 1914.

County Phenylketonuria Screening Program

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Elkhart

PHENYLKETONURIA (PKU) is an inborn error of metabolism in which the patient cannot metabolize the amino acid phenylalanine. As a result, the blood levels of phenylalanine build up and phenylpyruvic acid, an intermediate metabolite, is excreted in the urine. The untreated phenylketonuric almost always develops severe mental retardation. If PKU is detected early and a low phenylalanine diet begun, the mental retardation can be avoided. [1]

PKU is easy to detect. There are simple tests for phenylalanine in blood and for phenylpyruvic acid in urine. Many investigators have recommended that all newborns be tested for PKU.

There are several reasons why such a program of testing all newborns for PKU might best be carried out by public health agencies. First, PKU is a public health problem. La Du [2] reported that one percent of the population in public mental institutions are phenylketonurics: on the average, each of these in his lifetime will cost the public $100,000. Second, it is probably easier to ensure that *all* babies are tested when the program is centrally controlled than it is when each hospital and physician's office carries on its own program. Third, the statistical data can be gathered more easily from one agency than from several. These data will also be more useful if they are collected under the same program rather than under several programs with varying procedures.

This paper describes one public health program of testing all newborns in a county for PKU and reports results obtained so far.

Material and Methods

In August, 1961, the Elkhart County Health Unit began a study to screen all newborns in the county for PKU. This study is still in operation and will continue into the forseeable future.

The procedure begins when the doctor who attended the birth of the child files the birth certificate; at this time the Health Unit obtains the names and addresses of the parents. When the infant is about three weeks old, the family is sent a PKU kit. The parents test the baby's urine with this simple kit and return the results to the Health Unit. When the results are received, they are recorded on the retained copy of the birth certificate.

The PKU kit comprises a letter of instruction, a folder holding three Phenistix † —a simple stick test for phenylpyruvic acid in urine—a color chart for reading the stick test and a return postcard addressed to the Health Unit. The letter asks the parents to test the child three times, when he is about three weeks old, about six weeks old and about eight weeks old. A previous report [3] suggests that nearly all cases of PKU can be detected by urine tests by eight weeks. If any of the tests are positive, the parents are to notify their own pediatrician at once and also inform the Health Unit on the postcard. The parents are also asked to inform the Health Unit if all tests are negative.

If the Health Unit does not receive the postcard in one month, they send a second request, in which they further stress the importance of testing for PKU. If this fails to bring an answer, no further requests are made.

Phenistix is made of a stiff strip of cellulose impregnated at one end with a ferric salt. Phenylpyruvic acid in the urine reacts with the ferric salt to give a gray to blue color. The stick can be dipped in a urine sample, passed through a urine stream or pressed against a wet diaper.

* Commissioner of Health, Elkhart County.

† Registered trademark of Ames Company, Inc.

One-half minute after wetting, the color on the stick is compared with the color chart. [4]

Discussion

Results of over 5,000 tests have been returned. Two phenylketonuric babies have been detected. They are monozygotic twins. The mother tested the wet diaper of one of the twins when they were about three weeks old and the test was negative. The kit was misplaced and not rediscovered until the twins were about five months old. At this time the mother again tested the urine of one of the twins and got a positive reaction. Further testing confirmed that both twins were phenylketonuric.

Although earlier estimates of the incidence of PKU were about one in 20 to 25,000, recent screening programs have suggested the incidence may be higher, as high as one in 10,000. [5] Our results suggest that the higher estimate may be accurate.

The 5,000 babies for whom results were returned are about 85% of all the babies born in Elkhart county during the time covered in this report. This compares favorably with some of the other programs reported. In a PKU testing program in Cincinnati, it was estimated that only 50% of the babies born in the participating hospitals were being tested. [6]

Why is the return this high? One factor, surely, is the simple stick test procedure. The parents can do it easily and they know the results at once. Another factor is probably the return addressed card; the parent has only to make a few marks and mail it. It appears, not surprisingly, that the simpler the program the more successful it is.

Why have 15% of the parents so far failed to do these few simple things that might have such an important bearing on the health of their children? Nurses from the Health Unit called 47 recent failures to see if they could find any pattern.

Eleven of the respondents said they did the test but did not return the card. Apparently they did not think they had to return the card if the test was negative, although the letter of instruction said return the card whether the test is negative or positive. To learn the incidence of phenylketonuria, we have to know how many tests were done and were negative as well as how many were positive.

Seven said they did not receive the test kit. It seems unlikely that this many did not get the kit. More probably, they do not remember receiving it. Nine said they did not do the test but gave no reason—this group can be commended for their honesty, at least.

The other 20 whom the nurses tried to contact were unavailable. Some of them had moved; others had no telephone or were not at home when the nurses called. There was not time enough for the tenacious follow-up needed to get responses from those who could not be contacted in one or two telephone calls.

As an offshoot of the screening program, tests were run on some mentally retarded patients. This led to the discovery of an isolated community in the county with an abnormally high rate of phenylketonuria. [7] A newborn phenylketonuric was found in this group when 13 days old and the low phenylalanine diet was begun two days later. This baby is now over one year old and appears to be developing normally without any signs of mental retardation.

The people in Elkhart County have accepted the screening program very well. It is common for a parent to write a complimentary note on the return postcard, and the Health Unit has received many calls for further information about PKU and for additional PKU kits.

Summary

The Elkhart County Health Unit has, for over two years, been carrying out a program of testing each newborn in the county for phenylketonuria. The tests are done by the parents of the infant with Phenistix, a simple stick test for the detection of phenylpyruvic acid in urine. The parents send the results of the tests, positive or negative, to the Health Unit.

Over 5,000 infants have been tested so far under this program which has been well received in the county. One set of monozygotic twins with PKU has been detected. The 5,000 infants for whom results were obtained constitute 85% of all newborns in the county during the two years.

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313 N. Second St.
Elkhart ◄

Quick Test for Coronary Insufficiency

A simple, five-minute clinical test can rule out coronary insufficiency in the differential diagnosis of chest pain. The procedure was developed at the University of California at Los Angeles.

The test requires an injection of radioactive orthoiodohippurate (Hippuran). In the first 500 patients examined, the procedure proved accurate in diagnosis of coronary insufficiency, as confirmed by angiography. The key to the procedure is a special digital counter that records the precordial activity time precisely. Commercial models soon will be available for about $15,000 each.

The precordial activity time curve, produced by the bolus of radioactive Hippuran, is more prolonged than that of a simultaneously recorded curve produced by the same bolus downstream. The prolongation effect is caused by filling of the coronary vessels. The more rapid the filling, the greater the prolongation. Coronary occlusive disease shows a greatly decreased prolongation effect, readily distinguished even by a relatively untrained eye.

Dr. Harry A. Bishop who described this test at the meeting of the American College of Cardiology in Los Angeles believes that the test may spare many patients from angiography.—*Modern Medicine,* March 18, 1963.

Metronidazole* Therapy in the Treatment of Trichomoniasis

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Evansville

TRICHOMONAS VAGINALIS vaginitis, probably the stubbornest and most resilient problem confronting gynecologists, may soon become an obsolete disease. Early reports, all highly optimistic, on the effect of metronidazole in the treatment of this disease have now been substantiated in wider clinical trials.

In the July, 1963, issue of the *ISMA Journal,* Dr. Ralph T. Streeter reported his experience with this new drug.[1] Since that time, the Food and Drug Administration had cleared metronidazole for prescription use, so that it is now readily available to physicians. This paper is a report of the clinical application of this drug, together with some suggestions for its most effective use.

Although trichomoniasis is a benign disease, it is also a most uncomfortable one. The discharge accompanying the infection usually causes irritation and itching. Sexual harmony is frequently impaired and marital discord may arise. Because of their many loci of infection, trichomonads have been extremely difficult to eradicate. A few effective topical vaginal agents have been developed, but they are unable to reach the organisms lurking in the cervix, Bartholin glands, Skene's glands, and urethra; therefore reinfection of the vagina invariably occurs. The male prostate gland and urethra are also probable sources of coital reinfection.[2] All of these sites of infestation are impossible to reach topically, so physicians have rarely been able to produce a lasting cure.

An effective trichomonadal agent must be capable of reaching and eradicating the organism wherever it is found. Previous oral agents have been associated with various degrees of toxicity. Metronidazole, however, is a trichomonicide apparently free of toxicity when employed in therapeutic dosages.

Most Resilient Cases Used

For the purpose of evaluating metronidazole, 26 of the most resilient and stubborn cases of trichomoniasis were chosen. The average duration of the infection was three and one half years. All 26 patients had undergone prolonged and multiple treatments with little success. Two patients even had hysterectomies in attempting to cure trichomoniasis.

All the patients were treated with the recommended dose of three 250 mg. tablets daily for 10 days, except one patient with a severe infection who was treated with four tablets daily. In addition, 18 undiagnosed consorts were treated with the recommended male dose of two 250 mg. tablets daily for 10 days.

All patients reported relief of symptoms within a few days of beginning the 10 day course of treatment. A follow-up examination, consisting of a hanging droplet test of vaginal secretions, was performed usually one to three months after treatment.

The results were very impressive. Of the 26 patients treated, only three experienced a recurrence of the disease. It is significant to note that an extra-marital contact was discovered in two of these three cases. This emphasizes the importance of treating the male as well as the female, for it is now believed that trichomoniasis is a "social disease" characterized by a "ping-pong" pattern of infection. In these three recurrent cases, both the male and female were treated with a second course of metronidazole, and the infection disappeared, as determined by a second hanging droplet test which was negative.

Side effects were minimal. No patient discontinued treatment because of them.

* Distributed as Flagyl by G. D. Searle & Co.

Two complaints of coated tongue and one each of headache and candidiasis were reported by patients. One husband reported that he developed a slight rash. No neurological effects were seen. Similarly, no severe toxic effects were observed. In fact, there is a report in the literature [3] of a 16-year-old pregnant girl who swallowed 21 200 mg. tablets at one time, and no toxic effects were seen on either her or the fetus.

Total and differential leukocyte counts are recommended before, during and after therapy. In addition to the side effects observed in this series, diarrhea, nausea, dizziness, dysuria, depression, insomnia and edema have been reported by others as occurring occasionally.

Because of the possible hematologic effects associated with nitroimidazole compounds, blood studies were performed before and after treatment on 15 patients. No changes in the hemogram were noted.

Many patients reported that "marital cures" had been produced by the treatment.

Case Histories

A 49-year-old white female was first seen in November, 1961. She had a 13 year history of T. vaginitis, having been previously treated many times with vaginal creams and suppositories. Recurrent attacks of the disease caused her to suffer dyspareunia and concomitant marital discord. In 1959 an abdominal hysterectomy was performed in an attempt to eradicate the organism, but relief did not follow.

In October, 1962, the patient's vaginal secretions were examined by a hanging droplet test, and numerous trichomonads were found. She and her husband were both started on a 10 day course of metronidazole therapy. She noted some coating of the tongue, but her symptoms disappeared, and a repeat droplet exam in November was negative.

In May, 1963, the patient experienced a recurrence of symptoms and trichomonads were revealed in a hanging droplet exam. She and her husband were given a second course of treatment. A droplet exam in June, 1963, was negative, and the patient has since remained asymptomatic.

A 40-year-old white female was first seen in December, 1960. She had had a severe vaginitis infection for eight months prior to that time. She had experienced severe pain with intercourse, and sexual incompatability was so great that she and her husband had been separated for two months. She had been given the usual topical vaginal therapy without effect. In June, 1961, she and her husband began to see a professional marriage counselor, but their marital difficulties continued.

On July 27, 1961, the patient and her husband were both started on a 10 day course of metronidazole therapy. She was treated with four tablets daily, and her husband with two tablets daily. A repeat droplet exam on August 15, 1961, was negative, and the patient reported that she was completely asymptomatic and dyspareunia had disappeared. A follow-up droplet exam on April 16, 1963, was again negative and the patient reported that there had been no recurrence of marital discord.

Summary

Twenty-six female patients and 18 male consorts were treated for trichomoniasis with metronidazole. After the first cycle of treatment, all but three patients were cured. These three patients were subsequently cured following a second course of treatment. No serious side effects were noted, and mild side effects were reported by five of 44 patients. Marital and sexual harmony was noticeably improved in several cases, of which two sample case histories are presented.

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420 Cherry St.
Evansville ◄



The Case of The Rap of Raptorial Rapture

ARNOLD LIEBERMAN, M.D.
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"WOULD YOU CARE to join me in a bit of falconry over this Labor Day week-end, sir?"

My young British colleague had startled me many times before; he saw my utter bewilderment; hastily, I was being reassured. "We will go only to the eastern end of Long Island. A group of us has hawks; at this time of year, the flyways are being used by migratory birds going south. Have you ever *seen* a falcon being cast into the air and then watched her stoop on her prey?"

Before I could demur, this descendant of the British peerage launched into an animated discussion of the origin and development of this royal sport and the reviving interest being taken in it today. I was regaled with tales of Kublai Khan and his 10,000 hunting birds, each under the care of a separate falconer. The eagles and hawks are renowned birds of prey feeding on smaller mammals, reptiles, fish, insects and fellow birds. The day feeding members of this *raptorial* order range in size from the pigmy falcons, scarcely larger than sparrows, to the enormous eagles and condors.

The previous fall, my friend had been fortunate enough to capture a young female peregrine falcon. Did I know that the female *Falco peregrinus* is larger than the male? It was a fact for which there did not seem to be a visible good reason. The duck hawk, as the American variety is commonly known, is the only big dark falcon sporting a black mustache; the wings and back are bluish grey, the whitish underparts are barred with black on the breasts and the sides. *His* bird was some 18" in length and had a wing spread of over three feet. The duck hawk is the fastest bird in the world; "it is the most formidable bird of North America."

Jeff's enthusiasm carried the day; I arrived on a Friday evening. It was a relatively secluded bit of Suffolk county not too far off Long Island Sound. The "cottage" was really a mansion erected by some Wall Street tycoon of the late 19th century era. First we had a rendezvous in the main building with the other sportsmen and their wives. After a most leisurely and relaxing supper with all the usual (and unusual) trimmings, we all strolled over to one of the stables that held the falcons.

I felt that I had stepped into a different era. The birds roosted on special steel bars. They were hooded; leather straps (jesses) held their taloned feet leashed firmly to their perches. The men sheathed their hands with special leather gloves. The hoods were removed and each bird was fed some meat—not too much—by the respective owner. The fierce, glowering brown eyes, the sharp upper beak snapping down and over the notched mandible! Those terrible talons, three in front and the fourth in apposition from the rear, spreading widely and then clutching suddenly! The enormous pointed wings fanning out as the awakened birds flexed their bodies: most fascinating and unforgettable. *

At dawn the next day, we took off cross-country in a trio of Land-rovers: the English equivalent of our jeeps, sturdy, open vehicles adapted to rough terrain. Our bouncing buggy was driven by Jeff's wife; I held on beside her. In the back, my young colleague sat balancing the falcon on his fist; their pointer crouched on the floorboards. As we halted in mid-field, Jeff unhooded the bird's head and cast her into the air. The falcon soared up swiftly and almost vanished from sight; the dog went snuffing across the meadow.

Minutes later, the dog froze into the classical "point" position. I did *not* have time to see the peregrine roll over and plummet down on the bird that had been hiding in the tall grass. I did hear the harsh kak! kak! just before I actually saw the closed foot hit the mallard so stunning a blow that the feathers flew up in a shower! Through my binoculars I could witness in close-up the hawk darting upwards and then pouncing down to grasp its prey with outstretched talons. As the falcon held the doomed duck rigidly, its hooked beak reached over and broke the quarry's back: I could almost hear the sharp crack even as the beak snapped over the notched mandible. The pointer mouthed the lifeless form and trotted back to us with it. The falcon rose and soared gracefully in our direction; she landed on her master's gloved fist. The fires of feral joy, of relentless pursuit and chase, were still glowing in the predator's ferocious, brown eyes.

"A taste of the *rap* of *raptorial rapture*, don't you think?" My colleague always did have the gift of appropriate alliteration! The order of these birds of prey is *raptorial;* that *rap* by its closed foot certainly gave *all* of us—not only the falcon—a thrill akin to *rapture*. The British aristocrat was right! The aboriginal lust to kill is not too far under the skins of all predators: avian *OR* human

Many other unusual sights were witnessed by me that weekend: Still, that first swoop by the falcon—my initiation to falconry—will always be a vivid, blazing memory!

A Delitescent Dyspneic

The inevitable return to the city was not to be a letdown. I had accumulated far more than the usual number of critically ill patients demanding my immediate attention. Among these was a rather unusual gentleman I was asked to take over. Just the day before, he had come in as an apparently routine emergency. A car had gone out of control and climbed a curb; this man had been run over; the driver had fled. The stolen, abandoned auto was found just a few blocks away from the scene of the accident.

Even though the victim had fallen between the car wheels, he had not been hurt mortally or even seriously! Aside from the numerous, superficial abrasions, there was no evidence of broken bones or internal injuries. The spinal fluid was crystal clear and all skull x-rays were completely nor-

* References: *Nature's Secrets*, Halcyon House, edited by G. Clyde Fisher, NYC. *Complete Field Guide to American Wildlife*, Henry Collins, Jr., Harper & Bros. *The Peregrine Falcon*, Robert Murphy.

mal. The man had been knocked unconscious but had regained his faculties within the hour. To everyone's astonishment, he had not been rolled; there was an indecent amount of money in his intact wallet. He also had cards indicating full hospitalization coverage. He had seen me pass by; after he had been transferred to a semi-private room, he had requested to have me as his private physician.

The bandaged, scuffed face preserved the man's anonymity as did the (probably) assumed name. The long, tapering, muscular hands and fingers of my faceless patient stirred a vague memory but I gave no heed. The patient was on the critical list not because of the injuries but because of a marked dyspnea * that must have been developing over the years and had nothing to do with his most recent accident. The patient required an oxygen tent and felt even better when he had the additional comfort of a nasal catheter giving him more of the same. The differential diagnosis required no genius: just a cursory examination of the thin, even if still well-muscled chest revealed severe pulmonary fibrosis and emphysema. The usual x-rays showed a really extraordinary amount of anthracosilicosis; also, the apices were honeycombed with ancient, far advanced cavitary tuberculosis. * * The pulmonary function tests were really a supererogation. They were so far below the supposed minimum of 20% necessary to maintain life (according to text book consensus) that the patient should have been dead—it is a good thing that he did not know it.

Twenty years stoking the fires in the hell-hole of a coal burning ship could not have seared this man's lungs more. However, his body had continued to accommodate to a steadily diminishing O_2 supply: one can only marvel at what nature can do.

Just for the sake of completeness, we requested a bronchoscopy. We were further amazed to discover that—almost anticlimatically—there was a not so early bronchogenic carcinoma in the right middle lobe! Most obviously, this patient was not long for this world. Was it my duty to tell him so? His stated occupation of laborer was an obvious phony. His affluence and intelligence, the long, clean fingernails—the muscular hands innocent of callouses . . . Well, we doctors are not always as good as Dr. Conan Doyle's Sherlock Holmes; still, we can draw deductions from what we see and we *are* trained to *look*. My soon to be dead patient could be a professional person: musician? actor? gymnast? but certainly not a laborer. His English was good even if it had the flavor of a South European who had come to the States as an adult.

Mycologistic Mayhem

An evening or two later, I happened by. As I was standing there he reached under his pillow and pulled out an elegant wallet. From it, he extracted several Ben Franklins and handed them to me, "Here, doc! on account!"

The concealing bandages had left his now exposed face. The deeply sunken, smolder-

* Case of the Meek Matriarch, *JISMA* 56:3, March, 1963, pp. 315-321.

** The "white plague" no longer kills 20th century Keatses at 25 and Chopins at 40. Since the advent of TRIPLE THERAPY, viz., streptomycin, isoniacid and para-aminosalicylic acid, tbc. has tumbled from its dread first place as a cause of death in the 19th century, down and down until now it is no longer in the first ten! And there are other drugs that are useful: viomycin, pyrazinamide, cycloserine, kanamycin and ethionamide to name just five.

In a footnote, one can only editorialize and not teach. A great scholar such as E. R. Long can spend a lifetime writing on *The Chemistry of Tuberculosis*. A first class research worker such as Sol Roy Rosenthal of the Hektoen Institute in Chicago can spend almost four decades working "just" with BCG, Bacillus Calmette Guérin, and its prophylactic applications; he is the developer of the tine test (manufactured by Lederle) that makes it simple and easy to perform the skin test for this still dreaded affliction. Just this year, there has been work showing that *killed* BCG is effective in the prevention of tuberculosis. People born at the turn of this century carry in their chests the telltale Ghon tubercles. It is not too much to expect that our children will be born to live in the 21st century and learn to regard "the white plague" with the same detached curiosity that we display to now conquered killers such as bubonic plague (flea-borne) and typhus fever (louse-borne).

Of course, all this roseate speculation presupposes that radioactive fall-out will not wipe out the entire human species: but that is another story. . . .

ing brown eyes were restlessly intelligent. The big hooked nose floated over a formidable moustachio; the thin lips were drawn over a row of gleaming teeth; the chin jutted out strongly. This was a tough hombre—a condottiere who would not flinch at the truth or any other dire tidings —*where* had I seen him before?

Even as I was preparing for the opening gambit of unvarnished truth, the nurse came to tell me that I was wanted on the telephone. It was five minutes ere I could return. In my absence, the nurse had procured a deck of cards for the patient. Even while panting within the tent, the man had sat up and was riffling the pasteboards. With masterly dexterity, he was performing prestidiginous feats of manipulation. His mind may have been elsewhere, but here was a master gamesman! And—all in a flash—I knew my man! This was SHEENY SAM *, the fabulous buddy of Hans Hell! Nobody else could have such miraculously nimble fingers; that predatory, pirate's face! The tremendous muscular gymnast's body was wasted but still grimly formidable! I recalled the stories I had heard of this man's Catholic Sicilian father and Jewish mother (raison d'etre of the nickname)—of his fabulous coups at the green tables—of his ferocious skill with the leather-thonged garrote But, wait a minute! Had I not read of his sensational death at a Cosa Nostra "family dinner" (along with several other hoodlums)? What was this? Surely not a reincarnation!

Alerted, startled, disconcerted—and a little goosepimply—I slowly advanced further into the single bedroom. The private nurse was sitting in a chair; the TV was on. In his breathless, harsh, almost cawing voice, my patient rasped, "Ah, there, Miss Smith! Would you do us the favor of getting a couple cups of really strong, very black coffee? Please, don't come back before five minutes."

My no longer anonymous patient gazed me square in the face, "I see that now you know me; well, doc! Where do I stand?"

I paused for a deep breath—went to the door to make sure we were alone—and took the plunge. "You are Sheeny Sam—and I first met you when you were with Hans out West?"

"Right, doc! I picked you because I knew that you would not blab. Funny, running into you here—thousands of miles from elsewhere, isn't it?"

He looked into my eyes steadily, calmly and knowingly, "How soon am I being called to join Hans?" After another deep inhalation, he went on, "I've had lung hemorrhages for many years but the one a couple weeks ago was a real lulu. The last doc I had told me that he did not understand how I got around with the frayed garbage I call my lungs. There are a couple things that need my attention."

"Well, Sam: I'm not adding any information you do not have. Tell, me, though: how in tarnation did you let yourself get in this shape? And what is that story about your, ah, official demise?"

"Oh, doc, my lungs had been pretty well burned out long before you croakers found these newfangled T.B. cures. I've smoked three packs of cigarettes every day since before I put on long pants. And I did my gambling in rather smoky rooms, too—don't you think?

"Now as to that disappearance: you remember that compadre of mine who was at the game you saw? Well, one day I go to a 'family dinner' at a mutual friend's home. I had had arguments with the boss but I just could not believe that he would give me the 'Kiss of Death' right there while we were having cocktails! Funny thing, I am an expert on mushrooms. Just by, shall we say coincidence—I happen to have in my pocket a handful of the 'death-cup' roots as well as the 'death angel'. * It was not too hard to get to the kitchen and slip the stuff all unnoticed into the soup. Then,

* Case of the Devil's Mercy, *JISMA* 54:11, Nov., 1961, pp. 1652-1659.

* "Death cup" — *Amanita muscaria* — produces symptoms within minutes of ingestion: lacrimation, sweating, miosis, abdominal cramps, vomiting, confusion, collapse, coma and death with convulsions. "Death angel" — *Amanita phalloides* — will not produce symptoms for 6 to 18 hours after ingestion. However, the onset is dramatically sudden and devastatingly violent. There is extreme pain, nausea and vomiting, diarrhea . . . If the patient lives long enough, jaundice may develop. There is hypotension, CNS damage, subnormal temperatures and death within five to eight days.

when we were served, I could palm some of it, then pretend to choke on a swallow and go to the bathroom. Anyhow, within the hour they *all* got sick: and how! I went along and acted sicker than the rest. After they were all laid out like trussed fowl, I went among them, quietly, and helped the mushrooms with my rope. Yeah, it is always in my pocket and I just could have *no* one blabbing.

"Only then, could I afford to slip out the back door and go to a phone. I called a stoolie I knew and gave him the address and the names of the guys laid out there. I told him to be sure and have the police list me as among the dead: in return, I promised to sing like a canary. The cops did move in and my dummy was laid out in a very convincing coffin. And I *did* sing for them but private-like. This Joe Valachi is a nut and the Profacio-Gallo front page nonsense only shows what stupidos these guys are.

"Anyhow: I shaved off my mustache, changed my clothes and went off to a monastery—yeah, I got religion! But I had to go back to the big city; my lungs are giving out on me completely. Also, I guess, the 'families' are on to me; that car was no accident; they are looking for me."

Furious Phonomaniacal Finale

The longish discourse took the allotted five minutes. Also, all of Sam's breath had been used up. Even with all the oxygen running full blast, he was blue and gasping for more air. While I was sipping the black coffee, the nurse was busy making her patient at least a little more comfortable. My formidable charge had asked for the truth: he would have it.

"Sam, I must be honest with you. The last doctor is absolutely right; your lungs are shredded from smoke, they are moth-eaten with tuberculosis and the cancer that is growing there can kill fast all by itself. We can make you comfortable for as long as you have; the Good Lord alone knows the exact minute."

My patient did not flinch or even blanch. Completely unruffled, he nodded a quiet, "Thanks, doc; when I go, take my wallet and follow the instructions written out in



the sealed envelope. Nurse, please: do you hear? Don't worry about a thing, doc: everything most legal."

Sobered by these unsolicited (and unwelcome) confidences, it was high time for me to leave; there were places where I could be useful. I had a restless night and was up early the next day. The night shift had not left when I entered the elevator of the hospital. A man I did not recognize brushed past me and went down the hall even as I turned to pause at the nurses' station. Sam's chart indicated that he had had a fair night, all things considered. He had been bringing up the usual cupful of foul sputum but there seemed to be more and more frank blood admixed. The nurse had just gone down for breakfast; I ambled down the hall to the end room occupied by my unusual patient.

The door was ajar; as I paused outside, I could hear a brief scuffle and then a sudden thud; a gurgling gasp was strangled suddenly! As the door swung open, an incredible sight met my startled gaze. The critically ill—all but dead—Sheeny Sam



was bestriding the sprawled, prone, inert form of a man. Sam was pulling (what gave him that last surge of strength?) firmly at the thongs of a garroting noose cast around the stranger's neck. My patient's claw-like hands were curving his victim's back into an actual arc. Just as I stepped into the room, I could *hear* the sudden crack of the snapped neck.

Sam looked up at the sound of my entrance but he wasn't really seeing me. The ferocious fires of feral joy were glowing deeply in those fierce piratical brown eyes. Expertly, he flicked the noose loose and dropped it into the pocket of his bathrobe. He snorted his disdain, "Merde! Imbroglione." That hoarse croak—where had I seen and heard this before?

As the beaked nose snapped shut over the mustache and on the jutting mandible, I could hear the click of the teeth. And I saw . . . of course: the *Rap of Raptorial Rapture*: avian and human: *Falco peregrinus* and *Homo sapiens*. All the same

Even as Sam harrumphed, greenish pus and then ever redder slime began welling up—faster and faster—from his throat! Suddenly, a veritable torrent of blood, a hemoptysis to end all hemoptyses, spewed forth. The fierce predator swayed and fell prone over the body of the dead, would-be assassin. Some major vessel had ruptured; there was a final, shuddering, strangled, gurgling gasp and then: only silence

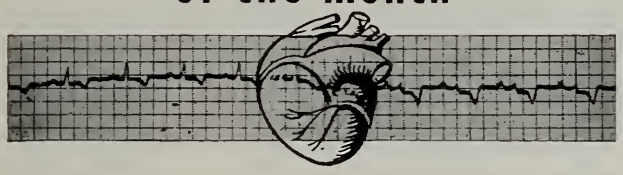
The nurses and attendants who came rushing in had a truly gory mess to clean. The killer noose I had managed to transfer most unobtrusively from Sam's pocket to mine. My conscience did not compel me to tell *all* that I had seen and heard. The very reputable voluntary hospital did not need sensational publicity; I am sure that the police identified the intruder; Sam kept the pseudonym under which he had entered the institution. The cause of death in his case was—most obviously—massive lethal hemoptysis from an eroded vessel. As to the stranger? Well, just as obviously, he had suffered "acute cardiac arrest" and, ditto, "respiratory failure." It was a certainty that he was neither breathing nor had a heartbeat.

The pathologists working for the medical examiner did a painstaking dissection of the coronary vessels; they were surprised to find them looking so well. The brain looked excellent, too. No one thought of removing the spinal cord or taking x-rays of the spine

A most worthy cause subsequently received a very substantial gift from modest Mr. Anonymous. Is there a better possible ending? ◄

1270 Fifth Ave.
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Electrocardiogram of the month



Presented as a regular feature of The JOURNAL, Electrocardiogram of the Month is a series of short talks on cardiovascular diagnosis and treatment, edited by the staff of the Krannert Heart Research Institute, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis.

Ashman Phenomenon

CHARLES FISCH, M.D.
Indianapolis

SUPRAVENTRICULAR BEATS, e.g. sinus tachycardia, atrial premature beats, tachycardia, flutter and fibrillation, when accompanied by aberrant intraventricular conduction, pose a problem of differential diagnosis from ventricular tachycardia. One of the physiological concepts, namely the relationship of the refractory period to the immediately preceding R-R interval, helps in differentiating aberrant intraventricular conduction from beats of ventricular origin.

Figure 1 is an example of the Ashman phenomenon. Lead V-1 shows sinus rhythm with some irregularity. There are two aberrant complexes preceded by a P wave, indicating supraventricular rather than ventricular origin and having the contour of right bundle branch block. Leads V-2 and V-3 show repetitive runs of atrial tachycardia, the first beat of each run being aberrant. The subsequent complexes, although as close to the preceding beat as is the aberrant to its immediately preceding complex, are normal in appearance.

The common denominator for all the aberrant complexes of each run is a preceding long R-R interval. Since the refractory period varies directly with the antecedent R-R (Ashman phenomenon), the first QRS complex of each run of atrial tachycardia falls in a relative refractory period and is therefore aberrant. Subsequent impulses, which come in rapid succession, follow short R-R intervals with their shorter refractory periods, activate the ventricles outside the refractory period and result in normal appearing QRS complexes. ◄

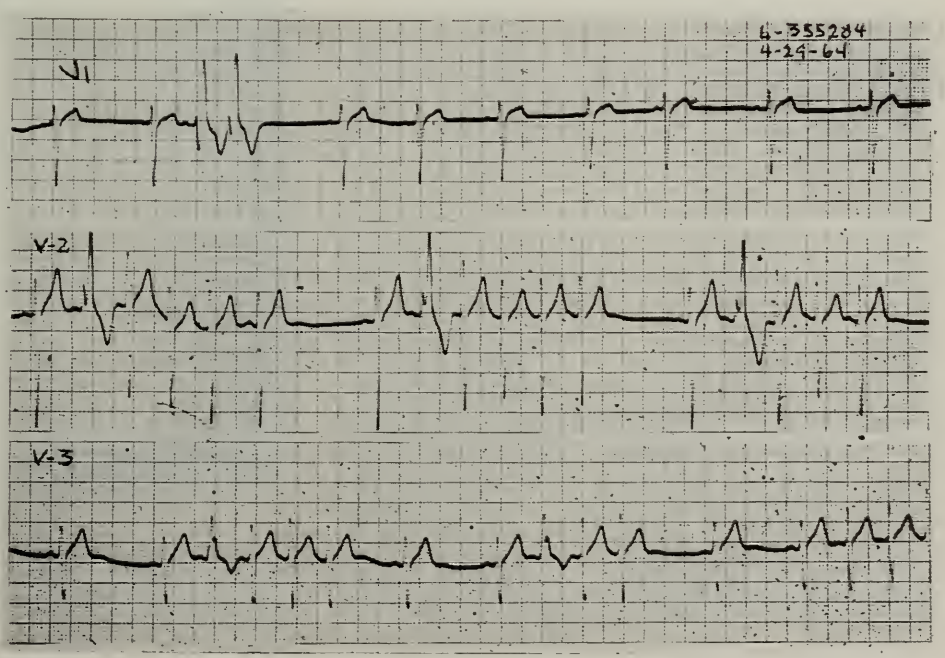


FIGURE 1
REPETITIVE runs of atrial tachycardia with aberrant first complex of each run.

X-RAY CONFERENCE

Presented as a regular feature of *The Journal*, X-ray Conference is a series of short talks on procedure and radiologic diagnosis, edited by Erich K. Lang, M.D.

Pulmonary Arteriography*

ERICH K. LANG, M.D. †
Indianapolis

A 38-YEAR-OLD white male was admitted to Methodist Hospital with complaints of left chest pain, a persistent cough and temperature elevation to 102° of two weeks duration. An admission chest roentgenogram revealed some pleural changes in the left base but no significant parenchymal disease. The salient feature of the patient's complaints was a rather excruciating chest pain over the left anterolateral chest area. Serial chest roentgenograms showed increasing pleural reaction along the left lateral chest wall, and mild loss of volume of the lingular segment as well as the lateral segment of the left lower lobe. There was no significant production of sputum.

A selective pulmonary arteriogram was performed to evaluate the patient for the presence of a pulmonary infarct or pulmonary artery thrombosis. Pressure recordings in the right atrium, the right ventricle and the pulmonary artery were all within normal limits. The roentgenograms revealed significant paucity of filling of the anterior segmental artery of the left upper lobe arising from the ascending branch of the left pulmonary artery. (Figure 1). The delayed serial films showed an absence of normal staining of the pulmonary capillary bed in a wedge-shaped triangle supplied by the anterior segmental artery of the left upper lobe. (Figures 2, 3). This established the radiographic diagnosis of pulmonary shower emboli into the capillary bed of this segmental artery with resulting spasm of both the main segmental artery as well as all pulmonary branch arteries.

The patient was placed on Coumadin



FIGURE 1

NOTE THE SELECTIVE injection of the main left pulmonary artery. The apical posterior segmental artery arising from the ascending branch of the left pulmonary artery is well seen. There is very poor dye filling of the anterior segmental artery of the ascending branch.

* Supported by grant of The Indiana Cancer Society, Marion County.

† Methodist Hospital of Indiana, Inc.

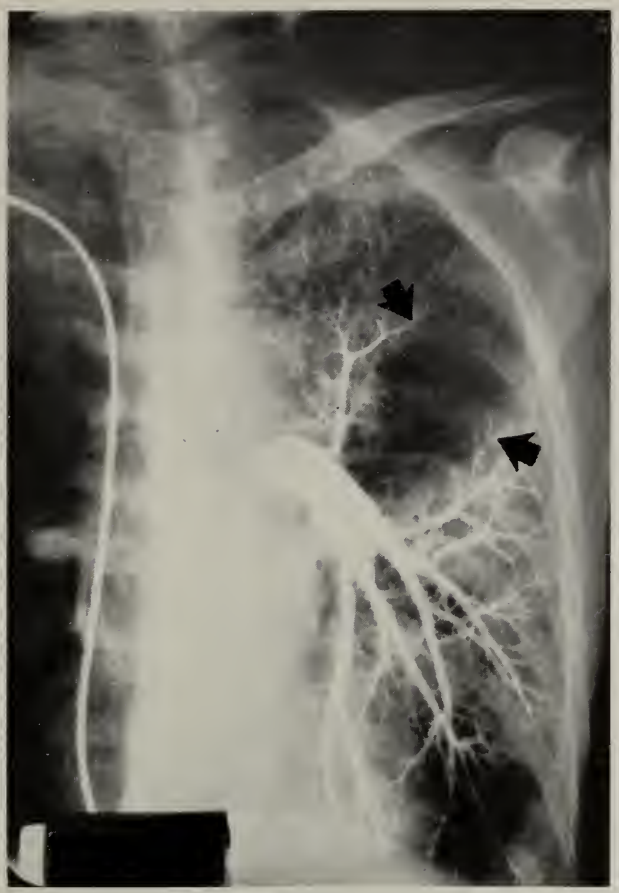


FIGURE II

THE EXCELLENT FILLING of the lingular segmental branches of the descending pulmonary artery are well shown here as are the branches supplying the left lower lobe.



FIGURE III

NOTE THE SIGNIFICANT absence of staining in the wedge-shaped supply area of the anterior segmental artery of the left upper lobe. This is felt to be caused by pulmonary shower emboli to its vascular bed.

therapy and recovered slowly.

Discussion

Selective pulmonary arteriography has become an important examination in the diagnosis of such pulmonary diseases as pulmonary hypertension, pulmonary infarction, congenital abnormalities of the pulmonary arteries, lung tumors, mediastinal tumors, and anomalies of the pulmonary venous return. The procedure is safe and extremely simple. A cut-down on an antecubital vein is performed and a Lehman catheter is advanced, under fluoroscopic control, through the superior vena cava, the right atrium, the right ventricle and finally into the pulmonary arteries.

Pressures may be recorded during the advance or the withdrawal of the catheter. An injection of approximately 40 cc. of 90% Hypaque into the main pulmonary artery or some 24 cc. into the right or left main pulmonary artery will suffice to give excellent visualization. Serial films covering a time period of no less than six seconds are recommended to demonstrate the main pulmonary arteries, the segmental arteries and the capillary bed vessels. The late films will demonstrate the venous return.

Conclusions about the presence of abnormalities can be drawn from the absence of any major branch arteries, splaying of any of the major branch vessels, failure of normal arborization or absence of the capillary stain. Anomalous venous return is readily demonstrated and the anomalous vein can be traced to its point of entry into the right atrium, superior vena cava or sinus of Valsalva.

This method is particularly useful for confirmation of a clinical suspicion of pulmonary shower emboli or embolization of one of the main segmental arteries. Pulmonary hypertension is likewise readily diagnosable and shows a classical lack of normal tapering of the third degree branch arteries with an abrupt cut-off of the arborization pattern.

Lastly, lung tumors are not only readily diagnosable by their characteristic splaying of the normal pathway of the vessels but also by the abnormal vascular supply to these tumors. Selective engagement of an artery supplying such a tumor can be used for embolization of the arterial bed of the tumor with radioactive microspheres. This method allows almost selective irradiation of otherwise inoperable lung tumors. Because of the highly selective fashion, a much larger dosage can be delivered to the tumor tissue since the integral dose normally limiting irradiation does not present a problem with this interstitial form of irradiation. Beta emitters with a very short effective range are utilized to guarantee almost selective irradiation of the tumor without deleterious irradiation of adjacent normal tissue. ◄

Threat to New Drug Research

It has been the experience of my company that the cost of development of a new drug for marketing is approximately five million dollars. I might add that the cost of other major pharmaceutical houses is about the same as ours.

If it is made more difficult and more costly to bring new drugs to market because of added red tape and restrictions—if a new drug can be barred because of conflicting views, honestly held but involving subjective judgments on its effectiveness—research is seriously threatened and indeed may be effectively foreclosed in the case of drugs for serious diseases which are not highly prevalent.

It is vitally important that development of new products of potential public significance not be shut off for such reasons, for the result will be to hamper seriously progress in the conquest of disease and the prolongation of life.—Theodore G. Klumpp, M.D., President, Winthrop Laboratories, to House Interstate and Foreign Commerce Committee, August 20, 1962.

LABORATORY MEDICINE

This page reviews established or relatively new but reliable laboratory procedures for physicians in general. It is not designed for specialists and laboratory personnel who would desire more technical information.

Chromosomal Analysis

WEI-PING LOH, M.D.*
Gary

RECENT IMPROVEMENTS in the technics of short-term tissue culture have made human chromosomal analysis less complicated and more popular.[1] It is now possible to perform such analyses with a commercially available chromosome culture kit and relatively simple equipment.[2] Because of recent advances, more significant chromosome patterns have been described and more genetically linked diseases discovered.[3] Much research is still going on; further improvements in technics and rapid gains in knowledge are anticipated.

Method

Tissues such as blood, bone marrow, skin and fascia lata, in which there are cells capable of dividing in culture mediums, may be used for chromosomal analysis. In a complete cytogenetic study, at least two different tissues should be cultured. Mosaicism may escape notice if only one tissue is cultured.

For convenience and simplicity, a peripheral blood sample and sometimes a bone marrow sample are generally cultured with a sterile technic. After a culture period of two to three days at 37°C, colchicine is added to the peripheral blood culture to retard the mitoses of the dividing leukocytes at their metaphase. The cells are then harvested and treated with hypotonic saline solution or citrate to promote swelling of the cells and dispersion of the chromosomes.

Smears are finally prepared from the cell suspension and further separation of the chromosomes is achieved by air-drying or by squashing. The smears are stained generally with orcein or Giemsa stain and examined under oil immersion or under a phase microscope. The chromosomes are counted in as many cells as manifest intact, well dispersed metaphase figures (Figure 1).

Photomicrographs are then made of the well dispersed metaphase figures having a modal count and are magnified to make 5″ x 7″ prints for chromosome identification and classification. In classification, the individual chromosomes are arranged in homologous pairs and in descending order of length. The chromosomes are classified into seven groups (A through G), and each pair has a numerical number (1 through 22) (Figure 2).

Bone marrow has greater cellularity and higher mitotic activity than peripheral blood. A direct method for chromosomal analysis may be applied to the bone marrow sample.[4] The whole process may be achieved in a few hours.[4,5]

Interpretation

The normal human chromosome number is 46 per cell (22 pairs plus two sex chromosomes). The male cell bears one X sex chromosome and one Y sex chromosome. The presence of two X chromosomes and

* Chief Pathologist, Methodist Hospital of Gary; Assistant Professor of Pathology, Chicago Medical School.



FIGURE 1
CHROMOSOMES in a well dispersed metaphase figure, as seen under dry high objective (approximately 900X).

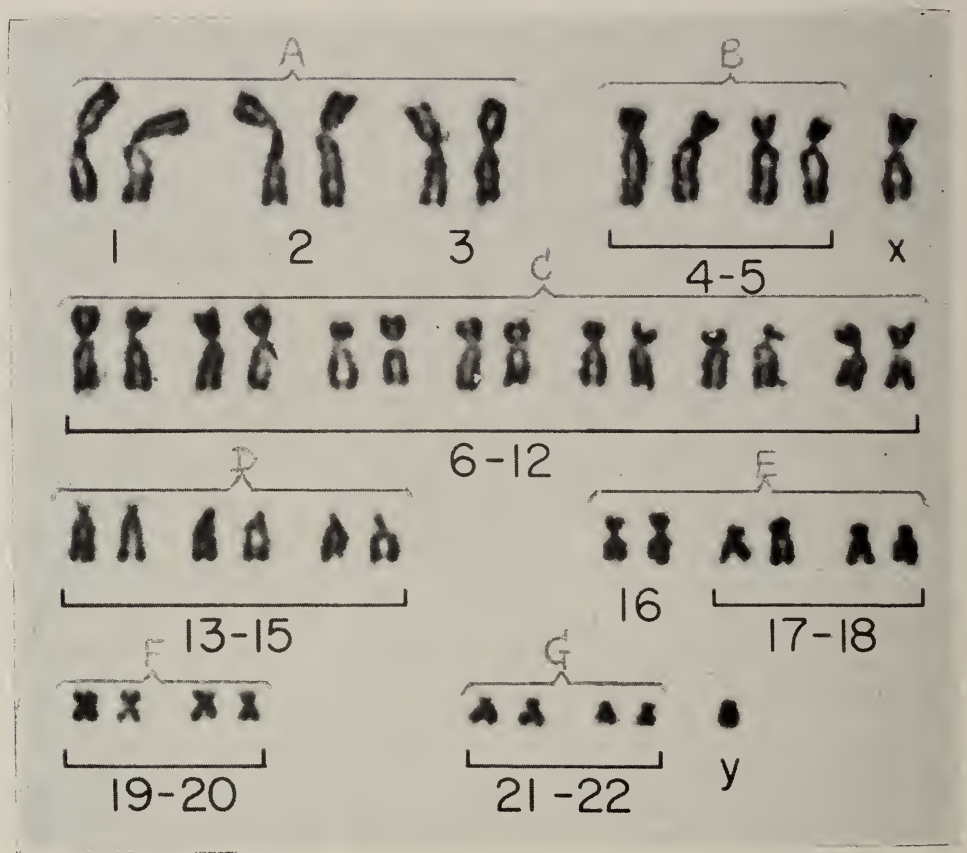


FIGURE 2
IDEOGRAM of human chromosomes (6,000X).

absence of a Y chromosome indicates a female cell.

Individual variations are usually due to technical factors and should not affect more than three percent of the cells examined. Chromosomal abnormalities have been observed in a large number of diseases or pathological conditions. The abnormal patterns are still poorly defined in many instances. The better known abnormalities which have diagnostic values are as follows:

CHROMOSOME PATTERNS

Chromosome Pattern	Pathological Condition
XXX	Triple-X syndrome or "super female"—mental deficiency and variable sexual findings.
XXY	Klinefelter's syndrome—microorchism, gynecomastia, mental deficiency, etc.
XO	Turner's syndrome—lack of female sexual characteristics, short height, sphinx neck, mental deficiency, etc.
Extra 21 chromosome (Trisomy—21)	Mongolism—sporadic and rarely familial, often born to older women.
21/15 translocation	Mongolism—familial type.
21/22 translocation	Mongolism—familial type.
Ph^1 chromosome	Chronic myelogenous leukemia—specific presence of Ph^1 chromosome in bone marrow, found even before development of clinical leukemia.
Ch^1 chromosome	Chronic lymphocytic leukemia—Ch^1 chromosome not always present.
Fragmentations and abnormal reunions	Seen in viral infections or following radiation.

SUPPLEMENT TO CHROMOSOMAL PATTERNS

Chromosomal Abnormalities	Disease or Syndrome
A. Abnormal Number:	
Sex chromosomal: XO	Turner's syndrome
Group C autosomal trisomy	mental deficiency
Group E autosomal trisomy	heart disease
Autosomal trisomy—21	sporadic mongolism
Sex chromosomal trisomy, XXY	Klinefelter's syndrome
Trisomy—21, monosomy—16	mongolism
Trisomy—21, monosomy—12	mongolism
Trisomy—Group F, monosomy—Group G	heart disease
Trisomy—21, XXY	mongolism and Klinefelter's syndrome
46/47—trisomy—21 mosaics	mongolism
45 XO/46 XX	chromatin positive gonadal dysgenesis
45 XO/46 XY	amenorrhea, hermaphroditism
45 XO/47 XXX	gonadal dysgenesis
45 XO/47 XYY	amenorrhea
?46 XX/46 XY	hermaphroditism
46 XX/47 XXY	Klinefelter's syndrome
46 XX/47 XXX	hermaphroditism
46 XY/47 XXY	Klinefelter's syndrome
48 XXXY/49 XXXXY	mental deficiency
45 XO/46 XX/47 XXX	chromatin positive gonadal dysgenesis
?45 XO/46 XY/47 XXY	amenorrhea
45 XO/46 XY/47 XXY	mental deficiency
46 XY/47 XYY/48 XXYY	mental deficiency
B. Abnormal Morphology:	
21/13 translocation	Marfan's syndrome
21/15 translocation	familial mongolism
21/22 translocation	familial mongolism
22/13 translocation	mental deficiency, heart disease
22—duplication ("partial trisomy")	Sturge-Weber syndrome
? isochromosome—2 or ? long arm 2/2 translocation	Waldenstrom's macroglobulinemia
C. Abnormal Number and Abnormal Morphology:	
Ph^1 chromosome (21 with missing segment)	found in over 70% of cases of chronic myelogenous leukemia
Ph^1 chromosome plus fragment	chronic myelogenous leukemia
Ch^1 chromosome (small 21 with short arms missing)	found in some cases of chronic lymphocytic leukemia
Extra submetacentric chromosome in inconstant abnormalities	acute myelogenous leukemia

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Drug Evaluation by the Practitioner

The practicing physician is an important component in drug evaluation. He should not be excluded. Many excellent controlled studies have been performed by well-qualified physicians, who are not members of a medical school or a research facility with a hospital environment.

Since the majority of patients treated by a physician are seen in private offices and the majority of drugs introduced into medicine are intended for these patients, it is essential that the evaluation include the practicing physician. Too often the results obtained in a limited group of patients, by competent investigators in scientific institutions, cannot be carried over to the treatment of patients in actual field trials.

The so-called controlled studies are occasionally so limited in scope, with removal of random variables, that the final conclusions do not reflect what can be expected when the drug is used in actual practice.—Robert C. Batterman to Western Pharmacology Society, San Francisco, January 28, 1963.

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

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Atomedic Goes to the Fair

THE REVOLUTIONARY Atomedic Hospital provides one of the most unusual features of the New York World's Fair.

Almost wholly automatic and incorporating the latest scientific and medical electronics, space and medical technics, the Atomedic Hospital serves as the official emergency hospital for the Fair's anticipated 80 million visitors.

The round, futuristic hospital is 100 feet in diameter, uniquely designed to provide for a center activity core, encircled by 22 rooms and ringed with an exterior corridor. A windowless structure, Atomedic is built primarily of light-weight Alply Aluminum panels. All structural elements and equipment are designed in units to allow for easy transport, assembly and replacement.

The World's Fair structure is the second Atomedic Hospital prototype. The first Atomedic is in Montgomery, Alabama, home of its founder, Dr. Hugh C. MacGuire.

Dr. MacGuire's dream was transformed into reality through the cooperation of a team of the nation's leading industries. Some 75 Alabama and national sponsors, ranging in size from America's biggest industries to a small three man shop in Montgomery, contributed their time, efforts and money to Atomedics.

Planned for use as an adjunct to established hospitals or for the many suburban areas and small communities now without a hospital, Atomedics is ideally suited for use in developing areas of the world as well.

During the Atomedic Hospital's sojourn at the Fair, an evaluation team of outstanding authorities on medical care will be at work. The group's study of this second prototype will include all facets of its operation—time and cost factors, equipment and all related data.

The team includes: Frank B. Berry, M.D., former Assistant Secretary of Defense (Health and Medical), who will serve as chairman; Walter J. McNerney, President, Blue Cross Association; Anthony J. J. Rourke, M.D., former President, American



THE ATOMEDIC HOSPITAL has proved to be structurally practical and sound. Constructed primarily of Alcoa Alply panels, a sandwich of two aluminum sheets with an insulating core of plastic foam, it is light and readily transportable. Aluminum structural elements for the entire hospital were loaded into four trailers, which were shipped aboard two flat cars to the World's Fair in New York, where the hospital was erected.

Hospital Association, now consultant in medical facility construction and accreditation; and George E. Armstrong, M.D., former Surgeon General of the Army, currently Medical Director, New York University Medical Center.

The team's findings are expected to be an invaluable aid in perfecting the design of future Atomedic hospitals.

The Montgomery pilot model began receiving patients in January of this year. After two months of operation, indications are that the cost per patient day, based on 80% occupancy, will be slightly under half that of the conventional hospital.

The initial construction cost is estimated to be 50% less than the cost of a comparably equipped hospital of conventional design. The average cost per bed of the conventional hospital is $30,000.

The World's Fair prototype will differ little from the Montgomery model, since time did not allow for major changes. Some improvements, such as the rearrangement of some storage space and the addition of a doctor's office, have already proved feasible through the Montgomery operation. Future hospitals will incorporate these, as well as the suggestions of the Fair's evaluation team.

Studies of the Montgomery prototype have already shown, however, that the Atomedic hospitals are a practical solution to progressive care in medicine.

Atomedic's nurses feel that it would be very difficult to return to conventional hospitals after serving at Atomedics. The saving of steps, the accessibility to patients, the extreme cleanliness, the simplicity of routine — all have freed them "from drudgery in one channel of service," and allowed them more time with their patients. The saving of two children's lives has been credited to the quick and easy access from room to intensive care area. The small staff of nurses and technicians quickly wove itself into a working team of the sort rarely existing in conventional hospitals.

Epilepsy – Symptom With Hope

ALEXANDER T. ROSS, M.D. *
Indianapolis

EPILEPSY, the "sacred disease," said to have afflicted Alexander, Caesar, Saint Paul, Napoleon, Lord Byron, and Dostoevski, and recently invoked fatuously as an explanation for crime, no longer is regarded with allegorical veneration. It is a symptom estimated to affect two million people in this country and a proportional number throughout the world. These are underestimations because the causes and the multifarious manifestations of this symptom increase as our experiences grow. Indeed, it is even difficult to define the condition. Perhaps a workable definition is that it is a sudden, recurrent, paroxysmal, transitory disorder of cerebral functions with or without motor manifestations or disturbances of consciousness.

It may occur as a generalized convulsion, a momentary lapse, a Jacksonian sensory or motor discharge, an episode of coordinated but inappropriate automatic behavior, an intermittent olfactory or visual hallucination. It may consist of any variety of psychical phenomena based upon real or phantasy experiences of the past—visual, auditory, intellectual, imaginative or emotional. Thus the strange feelings of reminiscence or reliving a previous experience, of compulsive thinking, of ill-defined fear, or other aberrations from reality. Here, too, are those seizures curiously triggered by alternating light and shadow, by specific sounds or kinds of music, by sudden loud noises or by reading with moving jaw or lips.

Some of these symptoms suggest a focus of cerebral dysfunction. Thus, the Jacksonian attack brings attention to the appropriate area of cerebral cortex; the formed visual hallucinations, automatisms and reminiscences to the temporal lobe; the sudden affective experiences to the limbic lobe and the intellectual seizures to the frontal. Discharges resulting in grand or petit mal apparently begin in the centrencephalon or upper brain stem. No consistent focus is found to account for the photogenic, musicogenic or reading epilepsies although the temporal lobe is suspected.

Having thus a general idea of the type and site of discharge, there remains the determination of its cause. These are multifarious and include such conditions as congenital brain malformations, trauma, infections, primary and metastatic brain tumors, degenerative and vascular lesions of the brain, and cardiac, renal, hepatic or metabolic disorders affecting brain function. The age at onset, historical data, duration, associated symptoms, results of physical, neurological and laboratory studies, radiographic and electroencephalographic information all provide clues, both positive and negative, upon which etiology and therapy are based. Refinements in diagnostic methods lead to a higher percentage of instances in which the cause of the epilepsy is determined; however, there remains a respectable number in which the etiology is undetermined.

If the cause is correctable or can be ameliorated by specific medical or surgical endeavors, these are undertaken. In most cases, whether the etiology is determined or not, anticonvulsant drugs, singly or in combination, are used. Each patient is an individual experiment to find which drug or drugs are most effective in his case—and no fast rules can be drawn. One strives to achieve maximal control of seizures short of intoxication. By the same token, duration of therapy is individualized. With such a regimen, effective control can be attained in 80% of patients.

Epilepsy has wide social, economic and educational ramifications. Here again its import is individualized. Some patients are inconvenienced little, if at all, and attain full educational, social and economic advantages. Some have such severe brain

* Chairman, Department of Neurology, I.U. School of Medicine.

damage—of which the epilepsy is but an associated manifestation—that they cannot fend for themselves and are wholly dependent on others. Some are highly intelligent but seriously handicapped by the frequency or severity of their seizures so that earning a gainful living is difficult. Others may be below average in intelligence but capable of learning a vocation and contributing to their support.

It is particularly with these last two groups that better understanding by parents, teachers, counselors, employers, legislators and the public gives hope and incentive to these handicapped persons. Epilepsy is so rarely inherited that now, in Indiana, persons with seizures are not sterilized and can marry. It does not cause criminal behavior. Wisconsin has shown that epileptics whose seizures are under medical control are no more prone to automobile accidents than the average population of drivers. Industries employing epileptics have found them industrious, responsible and disinclined to absenteeism. With prudent job assignments, the occurrence of injuries or property damage is minimized. When a teacher is aware that a student is subject to seizures, she can handle the situation calmly and intelligently and subdue the excitement of her other pupils. She may not anticipate it, but that child may some day make her exceedingly proud!

Thus, slowly but surely, the veil of mystery, fear and ignorance surrounding this symptom is being pulled aside.

A Lesson To Be Learned

THE ANNOUNCEMENT by the Food and Drug Administration that tranylcypromine (Parnate) will again be available to physicians—under improved safeguards—is a welcome one. This decision came on the eve of the public hearing requested by the manufacturer, Smith Kline & French Laboratories, to contest the action of the FDA in removing the drug from the market.

Such a hearing would have been basically of a legal nature. Although the array of witnesses drawn up by both parties consisted primarily of physicians, there is no reason to doubt that the course of the hearings would have been directed and determined by lawyers. At best this would be a far cry from a scientific inquiry.

We have been spared this spectacle as a result of "conferences between scientists and attorneys of the company and the Government." We are told that the present action of the FDA "was based on a study of the world medical literature on the drug, evaluation of controlled studies, and a consideration of the views of more than a score of specialists in the field of psychotherapy." The FDA states that the decision was based on two major considerations: the toxicity of the drug and whether its acknowledged effectiveness justified its use despite the known hazards.

All of this is eminently proper and admirable, but an unavoidable question arises. On what basis was the drug withdrawn? The implication is that a premature decision was made *without* study of the literature, *without* evaluation of controlled studies *without* consideration of the views of more than a score of specialists in the field of psychotherapy, and *without* consideration whether the effectiveness of the drug justified its use despite the known hazards.

This is most disturbing, and the lesson to be learned *must* be learned. The steps taken to *restore* tranylcypromine to the market are precisely those that should have been taken *prior* to the *withdrawal.* Obviously there would have been no withdrawal but, instead, a welcome tightening of indications.—Reprinted from *The Medical Tribune,* June 29, 1964.

Editorial Notes...

Dr. Austin Smith, in addressing the annual meeting of the Pharmaceutical Manufacturers Association recently, added a new consideration to the good news that prescription drug wholesale prices have declined every year for five years and are now

at an index of 86.2. Dr. Smith reminded his audience that there are those who insist that drug prices will go down only when patent rights are abrogated by law. His new bit of news is that while tabulating drug prices, the consultant, John M. Firestone, found that patented drugs had declined by 24% and non-patented ones by less than two percent.

The enlightened attitude toward the epileptic was given a tremendous boost by a *JAMA* editorial by Dr. Samuel Livingston, and by a letter signed by five medical consultants who testified at the trial of Jack Ruby. The five experts stated that "Neither the clinical history nor the electroencephalogram of Mr. Ruby indicated any definite evidence of epilepsy. Epileptic seizures are never associated with complicated and planned criminal acts of violence. Epileptics are as safe to be with as any group of people except in extremely rare and usually predictable situations."

Nitrogen is the most plentiful gas in the atmosphere. It is an indispensable element in living matter but cannot be utilized for the formation of protein until it has been "fixed" by chemically combining it with some other element. Nitrogen fixation on a commercial scale is expensive and involves expenditures of large amounts of energy. Professor Leonard Mortenson of Purdue has discovered how soil bacteria "fixes" nitrogen and forms it into ammonia. The process, which is essentially enzymatic, involves getting the necessary energy from adenosine triphosphate and the necessary electrons from the oxidation of carbohydrates.

The first lawsuit concerning the safety of Sabin oral polio vaccine has been decided in Oregon in favor of the pharmaceutical manufacturer, Charles Pfizer & Co. The suit was based on a dose of Type III vaccine taken in April of 1962. The patient suffered paralysis later and alleged the vaccine to be the cause. The defense was based on ample testimony as to the care with which the vaccine was made, on the tests to which it was subjected before being sold and to the record of safety accumulated with some 67 million doses administered.

"The average cost of producing a uniquely new drug product was estimated at 8.5 million dollars before the regulations took effect. Estimates indicate the cost of producing a new drug under the new regulations may approach 10 million dollars." C. Joseph Stetler of the Pharmaceutical Manufacturers Association makes the above statement and also notes that since the investigation of the drug industry began in 1959, the number of completely new products placed on the market by the drug industry was 62 in 1959, 39 in 1960, 34 in 1961 and 28 in 1962. Early returns indicate that there may be as few as 14 in 1963. He might have added that the real purpose of the investigation was purely political. Its announced purposes were lower drug prices and safer drugs. Its' actual effects have been higher drug prices, fewer new drugs, drastic curtailment of drug research and at the same time, no betterment for drug safety.

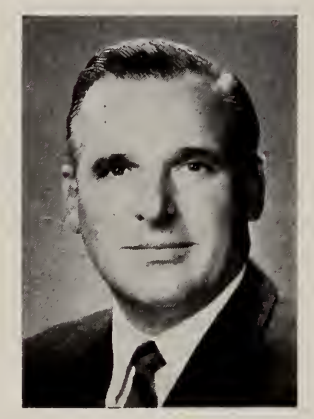
The Hospital Safety Contest in 1963 has been won by Tripler Army Hospital in Hawaii. Three hundred and seventy five United States hospitals competed to determine which one had the lowest employee injury rate. Eighty-two hospitals had perfect records; Tripler won by having the most man-hours of work since its last reportable injury. The 375 hospitals reported a total of 568,728,000 man-hours worked in the year with 3,380 injuries.

Mr. Elmer E. Lyon, an Indianapolis attorney, attended the Kintner Regulation hearings in Washington recently. He thinks that the proposed regulations, which practically eliminate the professional corporation as a tax saving entity, are invalid and will be set aside by the courts. He recommends that professional people should incorporate in all states where professional corporations are permitted, if they wish to take advantage of this method of setting aside funds for old age pensions without paying federal income tax at the time the funds are invested. ◄

President's Page

The American Medical Association meeting in San Francisco was very successful. The Indiana delegation comported themselves with dignity and represented the state association in a fine manner.

In one of the shops, I found a wall plaque with a bit of philosophy that I would like to repeat for you and your thoughts.



CHILDREN LEARN WHAT THEY LIVE

If a child lives with criticism,
He learns to condemn.
If a child lives with hostility,
He learns to fight.
If a child lives with ridicule,
He learns to be shy.
If a child lives with tolerance,
He learns to be patient.
If a child lives with encouragement,
He learns confidence.
If a child lives with praise,
He learns to appreciate.
If a child lives with fairness,
He learns justice.
If a child lives with security,
He learns to have faith.
If a child lives with approval,
He learns to like himself.
If a child lives with acceptance and friendship,
He learns to find love in the world.

If we all lived by this philosophy, our association would not be working on a proposal to present to the State Legislature in 1965 on the "Battered Child Syndrome."

JOHNSON —? vs. GOLDWATER—?

Donald E. Hood

PEPTIC ULCER • FUNCTIONAL HYPERMOTILITY • IRRITABLE COLON

PYLOROSPASM • BILIARY DYSKINESIA • PANCREATITIS • URETERAL AND URINARY BLADDER SPASM • GASTRITIS



PRO-BANTHİNE (propantheline bromide) Assures Authoritative Anticholinergic Control in Gastrointestinal Dysfunctions

The clear and consistent therapeutic benefits of Pro-Banthine (propantheline bromide) have made it the preferred anticholinergic for the past decade.

During that time, many compounds have been developed and proposed as alternatives. In the appraisal of Roach[1] ". . . few, if any, have seemed to offer a distinct improvement, . . ."

Early investigations showed that Pro-Banthine (propantheline bromide) reduces motility and acid secretion and may be used in a wide range of dosage, to bring prompt, positive anticholinergic benefits to patients with peptic ulcer, spastic colon, pylorospasm and related gastrointestinal dysfunctions.

Recent evaluations sustain these earlier judgments. In a current authoritative assessment based mainly on the factors of potency, superiority to atropine, clinical experience and physiologic study, Steinberg and Almy[2] select as the first two preferred anticholinergic drugs, methantheline [Banthine] and propantheline [Pro-Banthine].

The name Pro-Banthine (propantheline bromide) sets a stamp of therapeutic authority on any anticholinergic prescription.

Side Effects and Precautions—Urinary hesitancy, xerostomia, mydriasis and, theoretically, a curare-like action may occur. The drug is contraindicated in patients with glaucoma or severe cardiac disease.

Dosage—The usual adult dosage is one tablet of 15 mg. with meals and two at bedtime; this amount may be doubled or tripled for patients with severe conditions. Pro-Banthine (brand of propantheline bromide) is supplied as tablets of 15 mg. and, for parenteral use, as serum-type ampuls of 30 mg.

SEARLE

Chicago, Illinois 60680

Research in the Service of Medicine

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PEPTIC ULCER • FUNCTIONAL HYPERMOTILITY • IRRITABLE COLON

PYLOROSPASM • BILIARY DYSKINESIA • PANCREATITIS • URETERAL AND URINARY BLADDER SPASM • GASTRITIS

The Woman's Auxiliary

REPORTS TO ISMA

The 41st annual convention of the Women's Auxiliary to the AMA met in San Francisco, California, at the St. Francis Hotel, June 21-25, 1964. Delegates from Indiana were Mrs. John M. Sullivan, chairman, Mrs. Lester D. Bibler, Mrs. J. M. Black, Mrs. Frank Gastineau, Mrs. Francis Gootee, Mrs. Paul H. Martin, Mrs. John M. Paris, Mrs. Jack E. Shields, Mrs. Stephen D. Smith and Mrs. William R. Tindall. Alternates were Mrs. C. R. Chambers, Mrs. Max Ganz, Mrs. Wm. Burleigh Matthew and Mrs. Max Norris.



Auxiliary members attended the opening of the AMA House of Delegates where Dr. Edward R. Annis reported on his year as president. Roses were presented to Mrs. Annis in recognition and appreciation of the sacrifices she and other physicians wives make in giving of their husbands' time to the public. Later Sunday afternoon there was a tea and oriental fashion show honoring our national president, Mrs. C. Rodney Stoltz, our president-elect, Mrs. William H. Evans and special guests. Dr. Donald E. Wood presided at the AMPAC "Party-Prediction Banquet" Sunday evening.

At the formal opening of the auxiliary convention Monday morning, our national president and president-elect made their reports. Mrs. John M. Sullivan represented the North Central Region in the memorial service. Leaders of national women's organizations were introduced at the "Guest Day Luncheon" and a program, "When Spiritual Guidance Helps," was presented by the AMA Department of Medicine and Religion. The Reverend Paul B. McCleave, LL.D., narrated. A minister, priest, rabbi, pediatrician, obstetrician and surgeon participated in the program. The afternoon session was devoted entirely to the auxiliary Homemaker Service program.

The presidents of the 50 states gave their reports on Tuesday morning. Past national auxiliary presidents and honored AMA guests, one of which was Dr. Lester D. Bibler of Indianapolis, member of the AMA Board of Trustees, were introduced at the luncheon. A check from the 50 state auxiliaries totaling $307,318.14 was given to AMA-ERF. Indiana auxiliary members had contributed $16,124.85 of this amount. Dr. Annis was the luncheon guest speaker. Reports of national chairmen at the afternoon session began with a skit entitled "A Good Right Arm," portraying how the auxiliary has grown in its assistance to the AMA. The skit was written and presented by Mrs. Norman H. Gardner, of Connecticut, program chairman, and Mrs. Burton Kintner of Elkhart. Mrs. Kintner later presented a program as safety chairman. The need for a substantial increase in membership was emphasized (encourage your wife to join). Mrs. Floyd K. Anderson, California, National chairman, International Health Activities, stated in her report, "If we could give a badge of merit for I.H.A. participation it would go to the state of Indiana." She said that in the past year, under the leadership of Dr. and Mrs. Wm. Burleigh Matthew, a total of 25 tons of medical and surgical supplies were collected by Indiana auxiliary members from interested individuals and groups and are now in use by needy people throughout the world.

Dr. Ever Curtis, AMA Speakers Bureau, spoke Wednesday morning and told us that as religious people, physicians wives must be informed and inform other individuals and

groups to fight for right in our government for the EVENTUAL GOOD of all citizens. Mrs. Frank Gastineau of Indianapolis, member of the AMPAC board, said, "We must master AMPAC or be mastered" and encouraged us to join our state political action committee (I-HOPE). National dues were raised to $2.00 for general expenses and to make it possible for every member to receive a copy of our national auxiliary publication, the new *Bulletin* which is designed to inform and interest every member.

There were 1,412 auxiliary delegates and guests registered and 989 junior guests, making a total registration of 2,410. Materials were distributed and are available to over 85,000 auxiliary members to help our new national president, Mrs. William H. Evans of Youngstown, Ohio, carry out our theme, "Better Health—Better World."

Bea Shields

The last of three articles on medical staffs, hospital committees and medical records.

Robert's Rules of Unparliamentary Procedure

III. The Phenomenon of Records

IAN ROSE ("Robert Rose"), M.B., B.S.
Kamloops, British Columbia

IT IS SOMETIMES said that the existence of good medical records is one of the marks of good patient care. While this may be true, good records are not the same as voluminous ones; yet in many hospital record departments volume is the main objective. Later in this communication it may become apparent why this should be so. For the present it is pointed out that volume involves time in checking and transcription and makes work for the records personnel. At the same time, while Dr. X. is writing records on patient N., he cannot be seeing patient M.—and this may not be displeasing to Dr. Y.

A simple example is the following. The statement made in the progress notes, "There is no significant alteration in the patient's condition in respect of that which was present yesterday," is often more acceptable than the simple notation, "No change." Yet the former contributes no extra information.

Another reason why a large volume is preferred is that quantity is easier to control than quality. Yet even quality of records is not an assurance of quality of medical practice; it only makes the type of medicine practised more observable. The use of records in the control of medical standards is based on a non-medical human characteristic, *viz.* that someone conscientious in one thing is likely to be so in all things. A physician conscientious in his record-keeping is likely to be conscientious in the practice of medicine.

A number of factors have been alluded to that are calculated to increase the amount of records demanded at the present time, but it seems likely that there must be another and major new factor to account for the phenomenal increase during the past two decades. Extensive and detailed research has been undertaken during the last 10 years and out of the mass of data available, light is beginning to dawn.

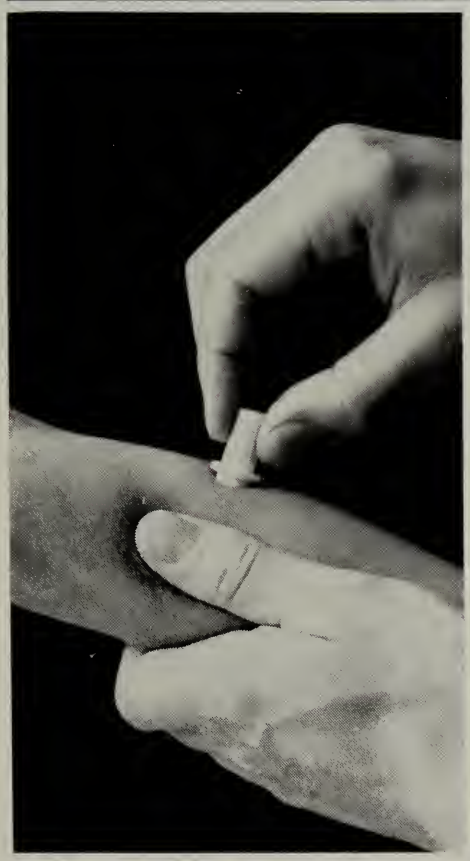
In 1952 Gobel, George and Steelcrance published a paper which attempted to show that the increase in volume of records was related to the conjugation of Sagittarius and the moon. While this was attractive to some, it was retrogressive and did not explain all the facts; certainly it has not stood the test of time. Two years later a startling paper came from Eastern Europe relating the increase in medical records to the estrus cycle of the Arctic axolotl. This concept never found acceptance in Western medical centres and is losing ground even in Murmansk.

The breakthrough began when Davies and Meed attempted to apply Parkinson's Law * to the phenomenon. They admitted from the beginning that some modification would be necessary. We have been proceeding along these lines.

The phenomenon of the increase of medical records really began with the appearance of the medical records librarian. The problem will be considered only in respect of a growing medical staff. In such a situation, before the appearance of a librarian, the increase in records is roughly in arithmetical progression with the increase in the numbers of the active medical staff. This is what would be expected with some vari-

* Parkinson, C.N.: *Parkinson's Law*, Houghton Mifflin Co., Boston, 1957, p. 1.







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Continued

ation owing to the increasing complexity of medical investigation and therapeutic procedures.

However, with the appearance of a medical records librarian, a change can be detected which is at first hesitant but later becomes more and more firmly established. The increase in records volume was at one time thought to be one of geometric progression with respect to the medical staff increase. On experimental trial this was found not to be so. Careful analysis showed that the increase of records volume was almost independent of the rate of increase of the staff. Evidence of this is contained in the findings in two hospitals. Over the period of the six-year study the medical staff of hospital A increased by nine members, i.e. from 38 to 47, while in hospital B the staff decreased from 40 to 39 owing to the death of one member. During that period the medical records in both hospitals increased: hospital A showed an increase of 140 volume units; hospital B showed an increase of 122 volume units. Clearly the variation of the numbers of the medical staff has only a minimal effect on the record increase.

An attempt to apply Parkinson's Law to this situation is not completely successful. Analysis at the present moment supports the following view.

A medical records librarian is appointed and proceeds to co-ordinate, clarify and index the records of the medical staff. This, if she or he is good, is potentially profitable. Once this is running smoothly she turns to increase the quantity and, to lesser extent, the quality of the records through the activities of the medical records committee. The point is ultimately reached when she is working efficiently and at her maximum capacity. But the medical staff is increasing in size. The time eventually comes when the volume of work is more than she can readily handle. Now there are two courses of action open to her. This librarian, whom we shall designate as A, can (1) ask for another medical records librarian, B, to share her work; or (2) for an assistant, C.

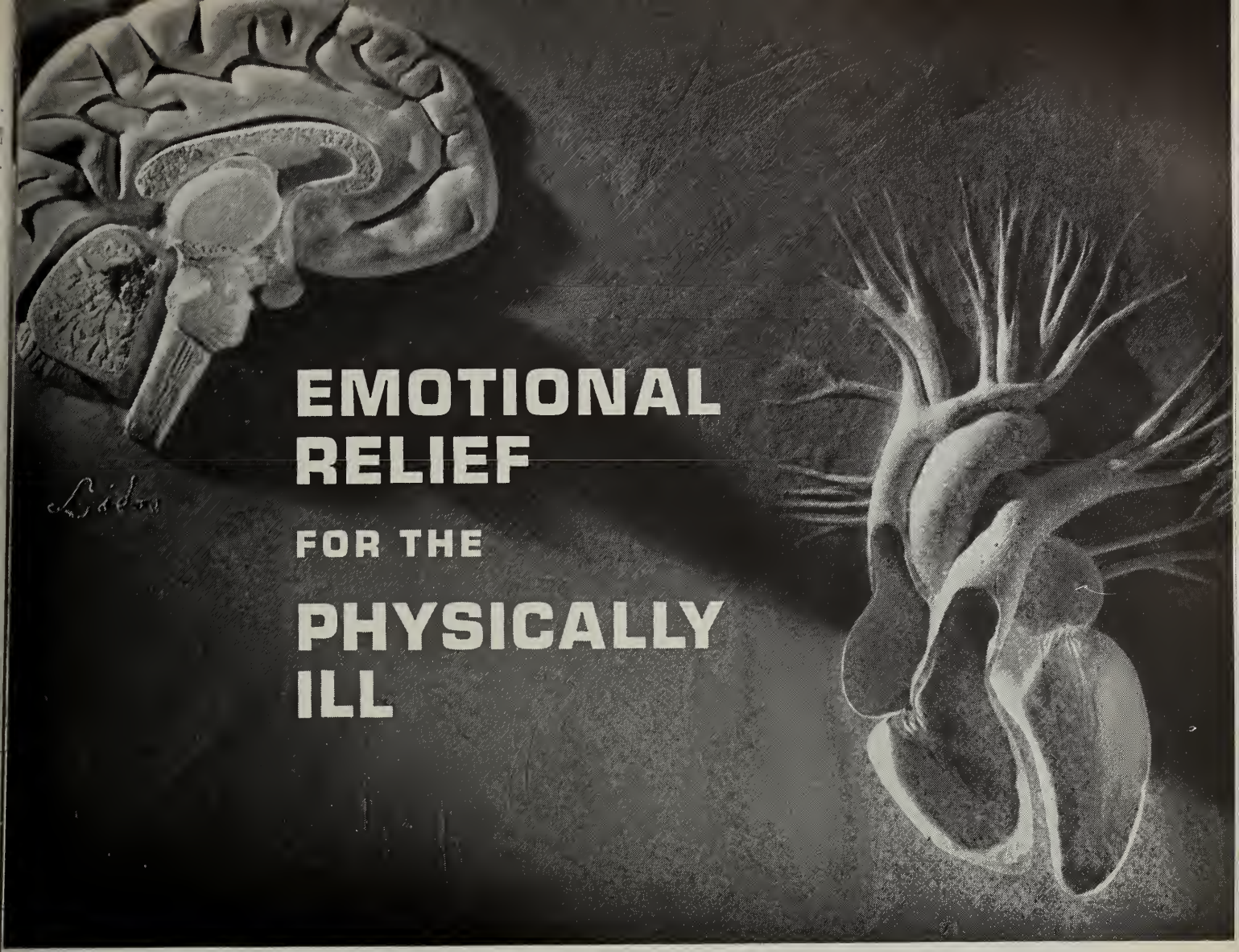
No instance is known where A has requested the appointment of another equal librarian, B. If she did so she would be introducing a rival who would have an equal potential of controlling the department. If, however, A should ask for the appointment of a colleague, B, the administration would not agree because obviously an assistant would demand a lesser salary. Therefore, A will ask for an assistant C. However, it is in the nature of things that two assistants are invariably appointed, if not at the same time then within a few weeks of each other. Thus, we have two assistants C and D, one looking after indexing and the other chasing doctors' signatures. Once C has been approved, the appointment of D is inevitable, because with two assistants, A is the only person who knows both C and D's jobs and thus A's position remains unassailable. In addition, C and D can be kept in control by playing one against the other.

However, a new situation has arisen. The work that was being managed by A is now divided among A, C and D. In order to justify their continued existence more work has to be created. This is done by increasing the watch kept on the records of the medical staff and increasing the demand for signatures and records from them. Of course this is done very subtly through the medical records committee. (The arguments used are logical if facile. They are of this nature: If one signature is desirable for good patient care, two signatures must be more desirable; if one-page histories lead to better medicine than two lines, then two-page histories are even better for the standards of medicine.)

The volume of the medical records increases and the medical secretary, N, needs two assistant typists, O and P, to handle the transcription. So that the department which used to consist of A and N now consists of A, C, D, N, O and P.

The time eventually arrives when A, C and D have created enough records to keep them reasonably occupied. However, this situation does not remain stable because the medical staff is still increasing and eventually the point is reached when C and D request assistants E and F, and G and H. At

Continued



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ROBERT'S RULES

Continued

the same time O and P are unable to cope with the transcription and need more typing help. So the process is repeated.

Thus, while this attempt to apply Parkinson's Law has led to the true explanation of the increase of medical records, it will be seen that the detailed processes in fact are different.

These findings can be expressed in the following formula:

$$x = \frac{2K(m+1) + a}{y}$$

where K is the number of staff in the medical records department; m is the number of man-hours they devote to indexing and classification; 1 is the number of man-hours they devote to transcription; a is the average period between the addition of new members to the medical staff in months; y is the number on the medical staff; x will be the period in months during which the time spent on records by each member of the medical staff doubles.

It will be seen that an attempt has been made to explain the phenomenon of records in this day and age. We are not yet in a position to recommend a therapeutic procedure that has been subjected to a properly controlled double-blind trial. Studies are being carried out and will be reported in due course. For the present we can only indicate that the considerable growth in records has all the signs of being a biological tendency rather than a readily treatable condition. We feel it will not respond to any conservative therapy, and even the efficacy of radical surgery is in doubt. We suspect that the ultimate solution is to be found in the realms of biological competition.

Gustason, Schnabel and Woo considered the introduction of a predator for the medical records librarian into the staff of the hospital. Accordingly they made a number of trials and, in an unpublished communication, they indicate that a suitable species may be the Unmarried Trainee Sub-assistant Administrator.

While we applaud any attempt to resolve this dark problem, we are fearful at the consequences of artificially interfering with nature's balance in hospital staffs. The introduction of a predator into the new environment may curtail the medical records, but is the Assistant Administrator to become a new plague?

We are indebted to C. Northcote Parkinson for his constant inspiration and without whose pioneer work this study would never have been conceived.—Reprinted from the *Canad. Med. Assn. J.* 89:308-309, 1963. ◄

The Tale of a Tail

An Indian was hailed into court, charged with not paying his income tax. He asked the judge why he should pay income tax, who painstakingly explained that Uncle Sam needed the money so that when he, the Indian, got sick or too old to work or lost his job, the Great White Father would be able to send him some money on which to live. A light of understanding flashed over the Indian's face. "Judge," said he, "that is just like my dog and me. When he work much hard he come to me, bark, and say, 'Boss, I work hard. Give me nice piece of meat.' I take big sharp knife, cut off piece his tail, and say, 'You good dog; you work much hard; here nice juicy piece meat for you.' He so dumb, he no know difference. It big laugh—he lick my hand for give him piece of his own tail."—Kansas City Rotary Club "Buzz Saw."



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Doctor Diplomats

More News from the Congo



FIGURE 1

THIS GROUP of small patients all suffer from tuberculosis, generally involving lungs and/or cervical nodes. Treated with standard anti-tuberculosis drugs—streptomycin, PAS and NIH—their prognoses generally are fair to good. Tuberculosis is very prevalent and poses a tremendous health hazard.

B. T. Maxam, M.D. tells this picture story of his three months stay at The Piper Memorial Hospital, Kapanga Methodist Mission Station, Katanga, Congo.

The photographs of Dr. Maxam and his patients were taken by Mr. Don Collinson, an agricultural missionary.

Dr. Maxam is one of approximately 12 Indiana physicians who have given free medical service in the Congo.

Under the sponsorship of the Indiana area of the Methodist church, physicians serve three months in an overseas area where emergency care is needed. Air transportation to and from the Congo is paid. The "Operation Doctor" program was begun by Bishop Richard Raines, of Indianapolis.



FIGURE 2

SMALLPOX PATIENT. This man came to the hospital covered with a mixture of human, sheep and goat manure which had been applied by a witch doctor. Our treatment of massive doses of penicillin proved far more efficacious! During my stay, there was a smallpox epidemic and we went round the villages and vaccinated hundreds of people but many others hid to avoid vaccination as their witch doctors had told them that they would be injected with "evil spirits."

The small child, in the picture on the right, is actually seven or eight years old. He has tuberculosis (lung involvement). After two months of treatment he gained nearly 10 lbs., and was beginning to walk.



FIGURE 3

THIS HUSBAND AND WIFE, both suffering from leprosy, are residents of the leper colony near the hospital. The huts are built by the patients and are numbered so that a record can be kept of the treatment administered to them. The treatment given now is sulfone drugs rather than chaulmoogra oil.

Note the mutilation of the husband's hands and feet. This is autoamputation from Hansen's disease. There had been no surgical amputation performed.

This child (right) had rickets, malaria and ascariasis. The rickets were treated with large doses of vitamins. Due to the angle of this photograph, the bowing of his legs is not quite as apparent as it was in actual fact.



FIGURE 5

THIS EMACIATED patient has tuberculosis peritonitis. One of his children lies on the mat beside him while his wife holds their other child. The roots in the lower right hand corner of the picture are manoic roots which, when ground, provide the staple food of these Africans.



FIGURE 6

THIS WOMAN posed a diagnostic problem. Her age was difficult to determine; she had a generalized edema but we were unable to find the cause. She did have severe hookworm infestation. The ulceration on her right foot we believed to be due to yaws, but there too we were unable to make a definitive diagnosis.



FIGURE 7

THIS BABY, brought to the hospital by his mother, was desperately ill with bronchopneumonia complicated by malaria and hookworm infestation. His recovery was complete.

Psychiatric Aspects of Leisure*

JANET R. MACLEAN, Re.D.
Bloomington

AFTER READING MUCH of the literature that has come in recent years from your colleagues, I decided that my first task would be a classification of terms so that we might better communicate and at least if I'm on the wrong track, you'll know which track it is.

Even the dictionary doesn't always have the right answer when words are used in different circles or among people with different backgrounds of experience. Two examples to illustrate my point come readily to mind. If those of you who are married were to call your wife a "vision," I'm sure that you'd elicit quite a different response from what you'd receive if you called her a "sight"—yet Webster's trusty Unabridged gives both terms like definitions.

A friend of mine has similar problems with his eight-year-old son. Standing high on a ladder, trying to hang the latest purchase for his art collection, he asked Karl to get him a screwdriver. After a lengthy interval, Karl returned with the message, "Sorry, Dad, I found the orange juice but we're out of vodka." We might recall the famous quotation of the Armed Forces commander who shouted, "We have not yet *begun* to fight." The wounded soldier lying near him groaned, "Somebody's always not getting the word."

I'd like for us all to "get the word" and that word is leisure, but I'm convinced that when you and I use the word, we give it different meanings. To be fair, then, I'd like to attack my subject of the "Psychiatric Aspects of Leisure" and I think there *are* some—first from my connotation—prerogative of "ladies first," you know—and then from yours.

If you have explored Kaplan's *Leisure in America*. Alexander Reid Martin's *Philosophy of Leisure*, or Sebastian de Grazia's new work, *Of Time, Leisure, and Money*, you will realize all too well that there is some confusion with regard to the word leisure. We range in definitions all the way from the simplest idea that most dictionaries promote, that leisure is "unobligated time, time away from work and the needs of personal maintenance, time to do as one chooses" to the concept that leisure is something aesthetically, morally and spiritually valuable with no relation whatsoever to a time concept. Many of your colleagues in their descriptions attribute to leisure all of the characteristics which members of my profession attribute to recreation.

Time on Our Hands

This then was my dilemma with your topic. I'd like first to look at the psychiatric aspects of leisure when you think of leisure as free time, unobligated, off the job hours which are yours to use as you wish. Assuming that we as a nation will escape the catastrophe of atomic war, revolution, or economic collapse, the American populace can look forward to ever expanding amounts of leisure. Our children enter the work force later; our adults retire from labor at an earlier age, and modern technology has considerably reduced the working hours of the interim age span which mans our labor front.

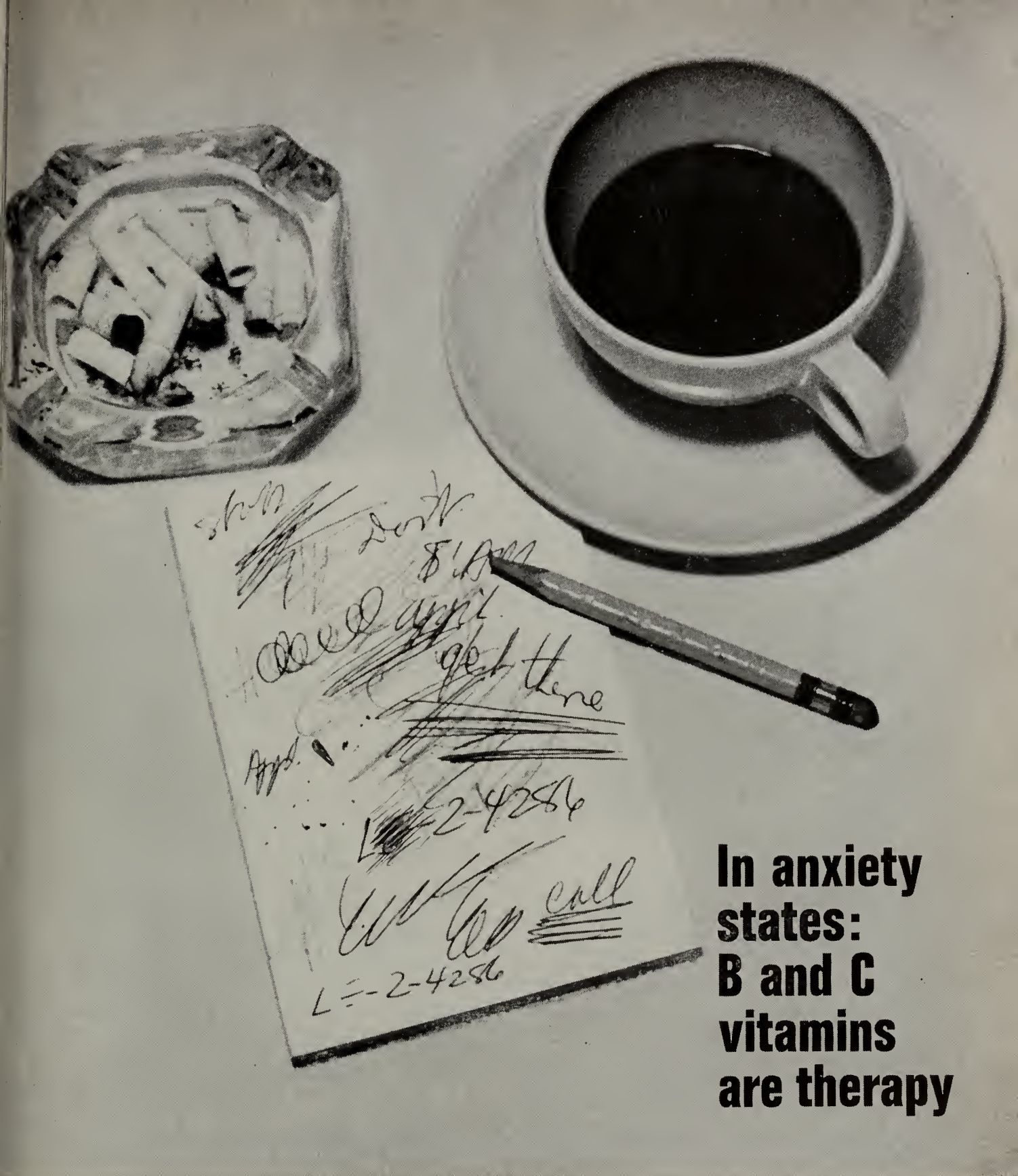
Within the past six decades the work week has dropped from over 60 hours to fewer than 40. The New York Electrical Unions are now working a 25-hour week. The combination of automation, labor laws, medical advances which have advanced the life span and compulsory retirement have added leisure in significantly larger chunks than ever before. Hours—two day weekends, one or two week vacations, five to eight-hour work days—why this is the Utopia that Sir Thomas More described four centuries ago.

What then is the *problem* in leisure? Un-

Continued

* Paper presented before the Northern Indiana Psychiatry Society Meeting, March 27, 1963.

† Associate Professor of Recreation, Indiana University.



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fortunately, amassing of leisure seems to be like the story of the cookie jar. When one grows tall enough to reach the jar, he's lost some of his taste for cookies. To suggest that leisure is filled with problems seems ridiculous. Isn't this what we've worked for? Most problems that confront us as individuals are ones that we've tried hard to avoid; yet leisure is something that we've worked to create, never realizing that it would bring us anything but joyful rewards. Like the young would-be naturalist who was surprised to receive a book on baby care when he wrote for a book entitled *Advice to Young Mothers*—the joys of leisure aren't quite what we expected.

Once the right to leisure belonged to only a chosen few—a leisure class which had enslaved a portion of the population to create their leisure—or those primitive tribes who dwelt where nature was bountiful. Now we have leisure for the many—over 70 hours a week of it—long enough to get us into all sorts of difficulties. We thus have more people with more free time. Let's look at the pattern of change that has taken place and point up some of the implications concerning leisure in these changes.

The Changing Pattern

1. *The nature of the work week has changed.* Since 1900, our national productivity has increased two-thirds in possible gain in goods and services, and one-third in leisure time. With a 40-hour work week, and a conservative estimate for sleeping and personal maintenance, we have more than 70 hours of leisure. When we worked longer hours, it was justifiable to regard leisure as that time in which we could relax and literally re-create ourselves to get back to the job.

Leisure in this century has far outstripped its re-creative needs to which it was formerly so thoroughly devoted. We must "shift gears" to a new concept of the worth of leisure. Old ideas die hard and the effects of hours of unstructured time unneeded to prepare for work are psychologically disruptive. We have worshipped the toiler, the go-getter, the burner of midnight oil; we've glorified work and condemned idleness so that when man no longer has an excuse for his many hours of leisure which used to be given to renew the light of the fires of work, he is guilt-ridden. Leisure brings him not pleasure but anxiety and a feeling of uselessness.

For the retired person, educated to a philosophy of the godliness of industry and the sinfulness of idleness, there comes an unbearable feeling of emptiness and depression. The imbalance of the work-leisure rhythm then creates a psychological impact. With an increase in leisure we have a growing incapacity to find satisfactions therein. We have what Dr. Alex Martin calls the "Sunday neurosis."

2. *The nature of work itself has changed.* A century ago our nation devoted itself essentially to handicraft manufacturing methods; a man sowed his seed and reaped his crop; he was his own boss; another took a fine piece of leather and from it created a beautiful pair of boots which someone purchased and praised him for his art. One of our greatest satisfactions in life should come from our work; work used to be the means for self-realization, fulfillment, recognition. One had a "calling."

Times have changed; for a vast body of our population, work is no longer rewarding in itself. For the factory worker and sometimes for the professional in the hierarchy of bureaucracies which now exist—in the fragmentation in the fine print in our own job descriptions—leisure must be the source for creative self-realization. Those opportunities for getting a bit of ourselves expressed must come in leisure in many instances or not at all.

3. *The third change comes in our environment.* In a three-generation rural household, each member of the family was needed, depending on and being depended upon, by others. For the pioneer, no one was concerned with worry about finding adventure—new challenges came daily in just eking an existence out of the soil, the forest or the stream.

No need to conjure up ideas for expression of aggressive desires; he was testing mental, physical, and moral fibers each day. In short, opportunities for satisfactions of

basic needs to keep his physical health and his psychological integrity were made to order—new experience and adventure, social participation, recognition in pride in achievement, response, creative experiences —and finally the security of even rhythm of sleep and wake, night and day, work and leisure to return to work. Time meant little; actual accomplishments meant a great deal. He engaged in a kind of elemental living in which although work took all of his energy and most of his time, it rewarded him with soundness of sleep and no need for tranquilizers, the "don't give a damn pills."

Today, as people, we still share the same kind of psychological needs as did our forefathers. While *we* have changed little, the environment in which we live has changed considerably. The Twentieth Century may be easier physically but *your* records attest to the fact that it is far from easy mentally. In our pushbutton era of the sixties we have yet to find one that is conveniently marked "relax"—although I understand some colleges are now offering courses in relaxation. (Not a bad idea, but wouldn't it be terrible if you wound up flunking *rest*?)

4. *A fourth change, which I think has a real bearing on leisure and our reaction to it, comes in the current trend toward group living.* We are segregated, truly so, not only by race, but by faith, by residential living, by schools, by age, by profession, by almost any other factor you want to name. About the only place in which we have vertical or heterogeneous groups is in the Armed Forces. Until a young man enters the service he may never see himself in perspective.

The suburban teenager without a car to play "Chicken on the Highway" in his leisure considers himself an underprivileged character and experiences all kinds of traumatic reactions if his leisure doesn't include the wherewithall, be it in tennis courts, swimming pools, or Sting Ray's to keep up with the neighborhood of Jones in which he lives. Going to Grandpa's farm on Sunday is no longer his idea of getting the most out of his leisure. As Russell Lynes indicates, "Nowhere are the pressures of leisure more intense than in that vast twilight zone of civilization called the suburbs, where a man's social standing rests not only on where he lives but where he must be judged by his leisure which must include bridge, the PTA, Little League, a finely clipped hedge and an affinity for political committees.

In short, we have compulsive use of leisure—a contradiction in itself. Lynes says, "Is it any wonder that there is beginning to be a movement of families back to the city where they can enjoy reasonable anonymity, involve themselves in just as many activities as they like, and be themselves?"

The situation in which we find ourselves is this: automation, incredibly fast means of transportation and communication, new labor laws which prevent child labor and cut work days, compulsory retirement, elongated life spans, medical advances which keep more people alive longer, improved living standards which allow us to buy discretionary time and urbanization have all combined to produce more free time, more leisure. But leisure is a two-edged sword; the world progresses or regresses not so much by what we do at work but what we do in our leisure. For creative efforts come when our mind is at peace—we don't make an appointment with an idea at our desks at 10 a.m. on next Monday morning. The idea may come as we chat with a friend or as we sit in a rocking chair. We're on the threshold of the age of leisure. The pressures of this age are increasing. How we use leisure may be the final test of our civilization. We don't want to have to resort to warfare to keep our people occupied. Fifty-mile hikes may not be enough to do the job.

Recreation and Mental Health

Let me turn quickly now to the second concept of leisure as those pleasurful, satisfying, enjoyable hours—in short, let's take a look at recreation, which to me is not leisure, though it takes place in leisure. How can recreation serve as an aid to good mental health? Possibly your own colleague Dr. William Menninger has been the most forceful exponent of this topic, with Ed Greenwood and Alex Martin coming a close second. We've already indicated that we have a unique problem today in that we as

a people are wholly unprepared for the large numbers of free hours available. We are misusing our leisure at many ages and it is causing us trouble.

Recreation is the only discipline in our culture which devotes itself exclusively to man's rewards derived from his free time. Let's approach the possible contribution from recreation in three ways: (1) as a preventive, to enable man, in this frightening tempo in which we live, to keep an even keel, (2) as an aid (therapy, if you will), to help him on the road back to normality after he has experienced mental illness, and (3) as a significant factor in *after care* in the community to which he returns from his illness.

In the first case, we need to change some attitudes toward recreation. It does *not* consist of sports and games solely; it is *not* just for children; it is *not* just a time-filler, a charity token or a deterrent for delinquent behavior. Recreation is a positive force and has positive values for all groups, sick or well, rich or poor, good or bad. Whatever it does to keep individuals from anti-social behavior is an important but secondary contribution. Because of some of the changes in our world today, we must find in leisure, in a whole gamut of choices, those satisfactions which we formerly found in work. And in those choices we must try to avoid social pressures and judgments.

I thoroughly enjoy symphonic music and am still capable of being enraptured as Indiana beats Illinois in basketball. I resent those who would have you believe that the first experience was a *better* one than the second for my leisure choice. We need to change some attitudes which will prevent not only a sense of guilt in having enjoyed either at all, but guilt in being able to enjoy something which someone else feels is less than cultural. The reverse is also true. How many unhappy ten-year-old boys do we have who are made to feel that they are less than manly if they choose to collect butterflies instead of playing baseball—or basketball if you are a Hoosier. How many twelve-year-old girls put away the bat reluctantly to play the piano in leisure because society says that girls who really like softball are tomboys and aren't apt to get the right kind of husbands later on.

Wholesome, satisfying, recreation experiences *can* help to keep our physical health and our psychological integrity but *only* if interpretation and social attitudes are such that we can really let ourselves go, can enjoy ourselves without the Puritan hangover of having to find a good excuse for that enjoyment. If recreation is to be therapeutic, and I believe it can be for the normal individual, we must then change attitudes and outlets. We must allow him to participate freely in experiences which are immensely satisfying, which are predicated on more than just time filling and more than just enjoyment. "Bread and circuses" are not enough; recreational opportunities must have meaning and depth and worth, if they are to aid in prevention of emotional difficulties.

A Basic Human Need

The plight of the aged populace today, *getting* old instead of *growing* old, should be teaching us some lessons in leisure at any age. I have a friend who, when he reached age 65, indicated that he'd now entered the Metallic Age—gold in his teeth, silver in his hair, and lead in his pants. Sometimes the lead assumes such proportions that it immobilizes the aged section of our population. And it isn't caused by physical inability; it's caused by mental depression. Intelligent attitudes toward the value and worth of wholesome recreation pursuits at every age must be fostered so that the idea of leisure for extended periods will not be a frightening thought, will elicit anticipation, not dread. We've got to stop being a nation that is so future-oriented that we cannot enjoy the status of retirement after we arrive.

Necessary also is the education of the populace to the idea that recreation itself is a basic human need and not the reward for having worked on a debit-credit ledger. It is this attitude that too often brings guilt in leisure to the mother who is playing with her baby while the dishes wait to be done, or the aged whose work is gone and his accustomed work-recreation rhythm is in imbalance. If mental health can be described not just as the absence of mental

Continued



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5. Hypersensitivity to carisoprodol may occur rarely. Codeine may produce addiction, nausea, vomiting, constipation or miosis.

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carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning—may be habit forming.)

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illness, but as an attitude, a frame of reference, which causes the individual to seek a fullness of life beyond mere existence, then recreation in my concept of the term, is a basic human need—as real as the need for food and shelter for every individual.

Rehabilitative Recreation

Our next case for the contribution of recreation as an aid to mental health is its use in the medical setting—as therapy if you will. And I see no controversy in having voluntary recreation used by a doctor as prescribed therapy. Recreation is always an end in itself but it may also be a means to an end. The worker in therapeutic recreation so inveigles, intrigues and stimulates his patient that what may have started as a "must" prescription becomes a satisfying recreation outlet. This to me is the challenge of my profession in a medical setting.

You've all experienced the bridge game, the opera, the ball game or the symphony which your wife insisted that you attend. And sometimes it turned out to be really enjoyable so that if the "leash" had been loosened midway in the evening, you still would not have left the scene. So it can be with patients. Those in our hospitals are struggling to regain their emotional equilibrium. The discussion groups, dances, sports activities or newspaper writing help them on the road back. I don't think I need to belabor this point, for you yourselves have been strong supporters of such programs in the hospitals in Indiana.

The sad situation here is one that exists in many areas—you whet appetites; you teach new leisure skills, you build rapport and confidence—and then the patient goes back into a community from which he came, a community in which he may not have a single opportunity to continue the enjoyable, worthwhile, significant experiences in which you have interested him.

This situation of course brings me to the third area of concern when we look at recreation as an aid to mental health—after care. If my information is correct, the whole interpretation of psychiatric responsibility has taken on a new look in recent years. No longer do you insist upon maintaining the patient in the psychiatric hospital until he has fully recovered. He must reintegrate as early as possible into the community after the refuge of the hospital. Here again is a place for recreation to play a part, if the recreation professional knows the patient is returning and if he is in a community which has felt sufficiently the importance of recreation in the social structure to offer a broad horizon of recreative opportunities.

And so we see that no matter from which point of view you look at leisure there are very real psychiatric implications in that leisure. What can we do to meet the problems and the challenges of increased leisure in our time?

First, let's recognize that we *do* have a problem. Just saying we don't have cybernation—a term coined to indicate the continuum which at one end has automatic producers of material objects and at the other the sophisticated analyzers and interpreters, both of which take away man work hours and human satisfactions,—doesn't solve the problem. Cybernation has not only posed unique problems in our society, but it has challenged our basic values and the ways in which we express and enforce them. Our future leisure classes, if predictions are accurate, will resolve into four classes (1) the unemployed, (2) the part-time workers with low salaries and short work hours, (3) the high salaried workers with short hours and (4) those professionals whose leisure may not have been reduced significantly at all.

For the first class, leisure will hold little pleasure because it is enforced leisure. It may be filled with kinds of activity but may hold little reward since this class has no discretionary money to allow them to make choices.

The second class may find difficulty in adjusting to the new freedom. They may, unless education radically changes, simply try to fill their time by moonlighting, taking another job or turning to destructive time consumption.

The third class, if education plays a hand,

will probably become the largest producers and consumers of leisure activities.

The fourth class will still be future-oriented in their thinking, and the scarcity of their leisure will make it attractive *until* retirement.

Education for Life

We are in a period of transition but for at least three of these classes we must have two kinds of education: First, education of attitude—we've taught young and old of the virtue of work, but our present life has taken away work from both of these age segments and reduced work hours for the rest of the population. We must then condition attitudes so that leisure is not only respectable but mandatory; it connotes not idleness and uselessness but enjoyment, service and experience with depth and meaning.

Secondly, we must stop focusing all education toward material production, the work years. Education must foster a nation of amateurs in the true sense of the word *amateur* from the Latin amo—to love—a nation of people capable of choosing for their leisure time wholesome experiences which they will literally love in the doing. I don't mean adding courses to the school curriculum. Heaven knows they're full enough. I do mean that if we are teaching for life, then we must recognize that leisure in life is going to far outreach work hours and we must teach what we teach with an inspiration, an example and a stimulation that will motivate toward use of any knowledge or appreciation or skill in leisure as well as in work.

We need research to better explore the relationships between recreation pursuits and mental and emotional health. We have a flood of energy in the area of physical fitness at present. We are spending billions of dollars on outer space. We must somehow convince people that we need equal time on research for knowledge of internal dynamics and the external forces which somehow inhibit and interfere with man's capability to live comfortably in a world and in a society which he has created. We need to subject leisure to systematic psychiatric observation.

Our strategy for living in this century is not so much a matter of new activity but new value. We're suffering from a special kind of boredom. As Clifton Fadiman reports in *Boredom, Brainstorms, and Bombs*, "This is a special boredom. Not unhappiness, not fatigue and certainly not aristocratic ennui, but that old, modern stunned look that comes of a surfeit of toys and deficiency of thoughts."

We need then to foster a new respect for leisure and the significance of recreation which appears in that leisure. We need to be able to enjoy without compulsion, without justification, without feeling that the Devil who, according to the Puritans, found work for idle hands is looking over our shoulder waiting to pounce on us. We need a society in which we accept the dignity and worth of recreation—not just as time filling deterrents to anti-social behavior but as positive living, the opportunity not only to live, but to live fully. Recreation as Paul Douglass says is "Unhurried, pleasurable living among one's spontaneous and educated enthusiasms."

When the education and recreation professions fail in their jobs, you in psychiatry open your doors to our failures. We need better interpretation; we need more creative opportunities; we need more adequately trained leadership so that we can get on with the business of discovering how to make our leisure as worthy, enjoyable, satisfying, honorable and creative a part of our lives as work. If we succeed, who knows—the lives we save may be our own. ◄

Artificial Insemination*

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ARTIFICIAL INSEMINATION is of two types, one (homologous, AIH) consisting of the injection of the seminal fluid of the husband by artificial means into the vagina of his wife so as to induce conception and the other (heterologous, AID) using the semen of someone other than the husband.

Although this procedure has given rise to a number of interesting and serious legal questions, there is almost a complete absence of authoritative legal precedence and statutes. It should be noted that AIH poses few, if any, legal problems, inasmuch as any child born of the procedure is the biological offspring of the husband and wife.

There have been a number of bills introduced on this subject in the various states; however, none of them have been enacted. A fairly typical example of the sort of legislation which has been introduced is the New York statute proposed in 1949 which would declare that a child born of AID with the "express or implied consent" of the husband is the "legitimate, natural child of both the husband and his wife for all purposes."

The City of New York in 1947 amended its Sanitary Code to require in connection with AI that a donor be given a complete physical examination, that donors suffering from certain specified conditions may not be used, that the Rh blood factor of the donor or donee must be determined, and, finally, that the physician performing the operation must prepare records showing compliance with these requirements.

A review of the relatively few court cases involving this subject indicates that a decision has never been rendered by a court of appellate jurisdiction in the United States and that the lower court decisions lack uniformity.

In *Doornbos v. Doornbos,* an Illinois trial court said that AIH "Is not contrary to public policy and good morals, and does not present any difficulty from the legal point of view." But of AID, the court said, "Heterologous artificial insemination, . . . with or without the consent of husband, is contrary to public policy and good morals, and constitutes adultery on the part of the mother. A child so conceived is not a child born in wedlock and therefore is illegitimate. As such it is the child of the mother, and the father has no right or interest in said child." The state's attorney appealed only from the decree of divorce, which was silent as to the legitimacy of a child born by heterologous artificial insemination, and did not appeal from the declaratory judgment wherein the question of legitimacy was determined. The court on appeal held that since the child was not represented in the legitimacy proceedings, the child was not bound by the adverse judgment determining him to be illegitimate. The appeal was dismissed. In a similar New York case, *Strnad v. Strnad,* a child resulting from AID, which had been performed with the consent of the husband, was held not to be illegitimate and the husband was given the right of visitation. It was stated as dictum, in a Canadian divorce case, that artificial insemination without the consent of the husband is adultery on the part of the wife.

The problems of legitimacy, inheritance, etc. primarily concern the parents and the offspring rather than the physician who performs the artificial insemination. The performance of artificial insemination does, however, create hazards for the physician which necessitate an adequate agreement between him and his patient. As is the case with other medical procedures, the physician cannot free himself from the obliga-

* Chapter 17 from Moritz and Stetler: *Handbook of Legal Medicine,* second edition, St. Louis, 1964, The C. V. Mosby Company. By special arrangement with the author and publisher.

tion to use due care and skill in the performance of the procedure itself.

The agreement with the parties should cover the following points:

1. The wife should consent in writing to the procedure because otherwise its accomplishment may constitute an assault and battery.
2. The written consent of the husband should be obtained because the procedure seriously affects and involves the marital relationship.
3. The donor should consent in writing to the unrestricted use of the semen he supplies and should certify that he will make no effort to ascertain the identity of the husband and wife involved.
4. Although the possibility of suit by her is remote, the written consent of the donor's wife to the giving of the semen may also be desirable, inasmuch as her marital interests are also affected.
5. The physician should have permission to use his own best judgment in selecting the outside donor. The law has not as yet delineated the responsibilities of the physician in this matter, but it would seem that he would be obligated to use reasonable care in selecting a healthy donor, who has no knowable transmissible disease.

There are certain other desirable precautions which the physician should observe. He should establish to his own satisfaction that, from the medical point of view, the husband is sterile. Where possible, the semen used should be "pooled," so that it includes semen of husband and donor. The use of such a "pooled" specimen would give rise to the legal possibility that the husband was the father, or at least it would make it more difficult to prove that he was not the father if the donor is of the same blood group. The physician should make certain that the identity of the donor is kept from the husband and wife and their identity kept from the donor. However, the physician should have a record, preferably in code form and open only to himself, of the identities of the donor and the husband and wife, in the event that such information later becomes necessary in defending litigation.

It cannot be too strongly emphasized that obtaining the consent and observing the precautions mentioned above may have a bearing only upon the physician's civil responsibilities. No court decisions and no statutes have as yet spelled out any criminal aspects of artificial insemination. If the procedure should be held to be a criminal offense, in all probability it would be the physician, rather than the donor, who would be regarded as the guilty party. The donor has no control over the use of the semen; it is the physician who, by his own voluntary act, has actually interfered with the wife's reproductive faculties and caused the birth of any child that may result. If the performance of artificial insemination should be held to be a criminal offense, the fact that the patient consented may not be a defense to the physician. It has generally been held that consent to perform a criminal act is a nullity.

Since neither the courts nor the legislatures have as yet made clear the physician's civil or criminal position with respect to the performance of artificial insemination, he should be insistent upon the greatest protection possible and should preserve adequate records in the event that any difficulties arise. ◄

Report on Actions of the House of Delegates

American Medical Association
113th Annual Convention
June 21-25, 1964
San Francisco

TWO INDIANA PHYSICIANS served on reference committees of the AMA House of Delegates at the national organization's annual meeting June 21-25 in San Francisco.

Dr. Guy A. Owsley, Hartford City, served on the reference committee on Public Health and Occupational Health and Dr. Jack E. Shields, Brownstown, on the Reports of Officers reference committee.

James A. Waggener, executive secretary of ISMA, was re-elected secretary-treasurer of the Conference of Presidents and Officers of State Medical Associations.

ISMA delegates, alternate delegates and officers attended the annual meeting.

Tobacco and health, human rights, physician-hospital relations, continuing medical education, the cost of medical care, and federal subsidization of prepayment plans and health insurance companies were among the major subjects acted upon by the House of Delegates.

Dr. Donovan F. Ward of Dubuque, Iowa, vice-president of the association, was named president-elect of the association. He will become president at the June, 1965, annual convention in New York City, succeeding Dr. Norman A. Welch of Boston, who was installed at the inaugural ceremony in San Francisco.

The AMA 1964 distinguished service award was won by Dr. Irvine H. Page, director of research of the Cleveland Clinic, for his investigation of cardiac, vascular and renal disease.

Final registration figures reached a grand total of 49,437, including 14,229 physicians.

Tobacco and Health

The house approved a strong stand on tobacco and health by calling cigarette smoking "a serious health hazard." This action was taken after the reference committee on Public Health and Occupational Health considered 10 resolutions and a Board of Trustees report on the subject and heard considerable testimony.

In adopting a four-point reference committee report, the house said "the American Medical Association is on record and does recognize a significant relationship between cigarette smoking and the incidence of lung cancer and certain other diseases."

It urged that programs be developed to disseminate vital health education material on the hazards of smoking to all age groups through all means of communication. The house also recognized the contribution of the Surgeon General's committee in its comprehensive report. And it emphasized that a joint committee of the AMA and the National Education Association already has adopted a resolution urging elementary and secondary schools to include programs on smoking and health in their health education curricula.

The house further recommended that the AMA pamphlet, "Smoking: Facts You Should Know," should be modified "in the light of accumulating knowledge."

Finally, the house said that the delegates and the Board of Trustees "should take great pride in the establishment of the research program on tobacco and health that is being carried out by the AMA Education and Research Foundation."

In adopting the report of the AMA-ERF the house called attention to the following statement:

"The board of directors of AMA-ERF and the Board of Trustees of the AMA were clearly aware of the possibility of criticism



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in accepting this grant (10 million dollars from several tobacco companies). But against that possibility they weighed the potential benefits to the public who will continue to smoke and concluded that the risk was insignificant by comparison. The only hope of minimizing the hazards of smoking lies in research which points to the course that the AMA as well as others must take."

Human Rights

On the major issue of human rights the house declared itself "unalterably opposed to the denial of membership, privileges and responsibilities in county medical societies and state medical associations to any duly licensed physician because of race, color, religion, ethnic affiliation or national origin."

This action was taken after the reference committee had heard a detailed discussion and had considered four resolutions on the subject.

In addition, the house called "upon all state medical associations, all component societies, and all individual members of the AMA to exert every effort to end every instance in which such equal rights, privileges and responsibilities are denied."

The house also accepted a report from the board on the liaison committees of the AMA and the National Medical Association. This report reviewed the history of the committees and noted that "great progress has been made voluntarily. More progress can reasonably be expected in the immediate future, especially if the committees are permitted to continue on a constructive, cooperative basis. This requires effort, but more importantly, goodwill and the desire to eliminate problems."

Physician-Hospital Relations

Conclusions and recommendations in a significant and extensive report on physician-hospital relations were adopted by the house. Prepared by the Council on Medical Service's Committee on Medical Facilities, the report stresses "the imperative need for the medical profession to assume responsibility for the quality, continuity, and availability of professional services and for the coordination of these services with the other essential supportive aspects of health care."

The report's recommendations are designed to serve as guidelines for physicians in meeting the problems involved in the changing patterns of care such as: appointment of salaried chiefs of staff; appointment of salaried heads of clinical departments; appointment of salaried directors of medical education; employment of salaried physicians for outpatient and emergency departments; use of salaried physicians to provide care ordinarily provided by interns and residents; and utilization of closed-panel prepayment medical care programs by hospitals.

The report also includes a review of the development of AMA's policy on physician-hospital relations, a study of the relation of policy to actual practice, and an investigation of the factors influencing change—including graduate education, medical finance, expansion of hospital functions and regulation of medical care.

Continuing Medical Education

Authorization was made by the house to establish an AMA-sponsored survey and accreditation program in continuing medical education. In the program attention will be concentrated on institutions and organizations offering courses rather than on individual courses, and appraisal of an institution's or organization's program will be carried out only at its request.

Eventually, approved institutions or organizations will be so designated in the council's annual lists of "Continuing Education Courses for Physicians," and when all institutions which wish to list their courses have had the opportunity to be considered for approval, only courses of approved institutions and organizations will be included in the annual list. Programs will be surveyed by a review committee on Continuing Medical Education.

Cost of Medical Care

A four-volume report of the AMA Commission on the Cost of Medical Care was received by the delegates, and the house concurred with the Board of Trustees that the

conclusions and recommendations of the commission will be studied and a report will be made to the house for its consideration at the 1964 Clinical Convention.

The four volumes include a general report on factors involved in medical care costs, a full report on "Professional Review Mechanisms," another on "Significant Medical Advances" and one on "Changing Patterns of Hospital Care."

In its report the board said that the commission "is aware that its efforts will not result in a magic reduction in the price of medical and hospital services. It does believe, however, that its study has produced a considerable amount of new and relevant information which will serve as a basis for better understanding by the public and the medical profession of this complex subject."

Reaffirmed the AMA policy favoring federal grants for "bricks and mortar"—funds for construction and renovation of medical schools, hospitals, related institutions and mental health centers—but urged that the "advantages and desirability of multiple source financing be kept clearly in mind." The house also was informed by the board that it is appointing a commission to conduct a broad study of the role of federal support of medical research.

Other Actions

—The house went on record as opposing federal subsidization of prepayment plans and health insurance companies, and it asked for an AMA study of the development of state programs which utilize prepayment plans or health insurance companies in the implementation of state programs of medical aid to the aging under the Kerr-Mills law.

—A proposal to poll all AMA members concerning compulsory Social Security for self-employed physicians was rejected by the house. In addition, the house concurred with the reference committee in opposing polls of the membership on issues of "great or even moderate importance" because the house members express the majority sentiments of their constituents on all questions coming before the house.

—An expanded program on medical ethics was endorsed by the house. The program will be designed to educate physicians and the public on what medical ethics means to them and how medical ethics affects them. The judicial council, working with the Board of Trustees, will determine the means by which this expanded program is to be implemented.

—Approval was given to a change in the bylaws to allow the house to set the hour and day of election of AMA officers at the annual convention. This was adopted early in the house session and made it possible to have the nominations on Wednesday afternoon and the elections on Thursday morning.

—A three-point communications program designed to improve the public relations position of the medical profession was endorsed by the house on recommendation of the AMA Committee on Communications. The program includes a redoubling of efforts by county and state societies, closer liaison with media personnel and prompt information to state societies on AMA news releases and testimony.

Miscellaneous Actions

In considering a wide variety of resolutions and reports, the house also:

Approved the creation of the Section on Allergy on recommendation of the Board of Trustees.

Approved a comprehensive inquiry of the causative factors for the sharp increase in syphilis and gonorrhea and urged the AMA to "take leadership in educational and research measures designed to control and eliminate syphilis."

Okayed a national conference on areawide planning of hospitals and related health facilities, to be sponsored under the auspices of the AMA.

Agreed to continue and broaden studies on the problems of unwed mothers, illegitimacy and other related matters and to develop positive preventive programs.

Supported a position statement on protecting children against physical abuse and called for legislative guidelines to the states relative to legislation on this matter.

Asked the Board of Trustees to investigate establishment of a wire communications system between AMA headquarters in Chicago and offices of state medical associations.

Referred to the Council on Medical Service a resolution condemning the practice by some hospitals of adopting constitutions which deny staff privileges to physicians not eligible or certified by specialty bodies or societies.

Agreed with the board that a forum for representatives of national medical specialty societies and the American Academy of General Practice be held on Nov. 1, 1964, in Chicago.

Approved a resolution calling for the publication of the proposed nominees for standing committees (councils) of the house be submitted in advance of the annual convention, preferably in the House of Delegates Handbook.

Recommended that the Board of Trustees use the talents of Dr. Edward R. Annis, immediate past-president, and other qualified spokesmen for medicine with appropriate remuneration.

Asked the Committee on Insurance and Prepayment Plans of the Council on Medical Service to consider a revision of simplified health insurance claims forms.

Recommended that the Board of Trustees approve the establishment of an ad hoc study on family practice as proposed by the Council on Medical Education.

Agreed with the change of name of the Council on Medical Education and Hospitals to the Council on Medical Education.

Requested clarification of the ethical and legal limitations of physicians participating in court-ordered, pre-trial psychiatric examinations.

Urged the AMA to continue its vigorous opposition to tax regulations discriminating against "professional associations" and "professional corporations" and its support of legislation which seeks to provide tax equality with business corporations for "professional associations" and "professional corporations."

Opening Session

Dr. Edward R. Annis of Miami, outgoing AMA president, told the special Sunday afternoon opening session that a greater effort is needed in the areas of continuing medical education and health education programs. He also urged state and county medical associations to bolster their paid executive personnel to help carry out local, state and national projects. Doctor Annis called for an increase in AMA dues and later the house referred the question of a dues increase to the Board of Trustees for study and for a report at the 1964 Clinical Meeting in Miami. Honored at the opening session were the presidents of state and territorial medical associations and a number of special AMA guests from national organizations.

At the Monday session awards announced were the AMA Scientific Achievement Award to Prof. Rene Jules Dubos, Ph.D., of the Rockefeller Institute, New York City, and the Joseph Goldberger Award in Clinical Nutrition to Dr. William J. Darby of Vanderbilt University School of Medicine, Nashville.

Inaugural Ceremony

Doctor Welch, in his inaugural address Tuesday night, said that medicine must be united if it is "to serve the public in the future to the high degree that it has in the past." He stressed that American physicians must be "standing strong and firm with a heart and a conscience tuned to public need, with a respect for the rights and privileges of the individual and with an abiding faith in our free competitive system of medical practices."

In keeping with Doctor Welch's address, "Unity in Medicine," presidents or their representatives from 29 medical specialty organizations were honored guests at the ceremony.

The distinguished service award was presented to Doctor Page and the scientific achievement award was given to Doctor Darby.

Wednesday Session

Speaking at the Wednesday session, Doctor Welch pointed up the growing alliance between medicine and research—an alliance rooted in truth, knowledge and the freedom to search them out. He called these "the greatest assets available for human development and human well-being." Doctor Welch also enumerated the important projects of the AMA in the past years such as mental health, continuing medical educa-

tion, tobacco and health, and AMA-ERF, the Institute of Biomedical Research.

Election of Officers

In addition to Doctor Ward, the new president-elect, the following officers were named:

Dr. Carlton Wertz of Buffalo, vice-president; Dr. Milford O. Rouse of Dallas, speaker of the house, and Dr. Walter C. Bornemeier of Chicago, vice-speaker. Dr. Robert C. Long of Louisville was re-elected to the Board of Trustees for a three-year term, and Dr. Alvin J. Ingram of Memphis was elected to a three-year term. Doctor Ingram replaces Dr. R. B. Robins of Ark.

Nominated and elected to the Judicial Council was Dr. Charles C. Smeltzer of Knoxville, Tenn. Named to the Council on Medical Education were Dr. William P. Longmire of Los Angeles, and Dr. William A. Sodeman of Philadelphia. Elected to the Council on Medical Service was Dr. John Rumsey of San Diego, and re-elected was Dr. Willard A. Wright of Williston, N.D.

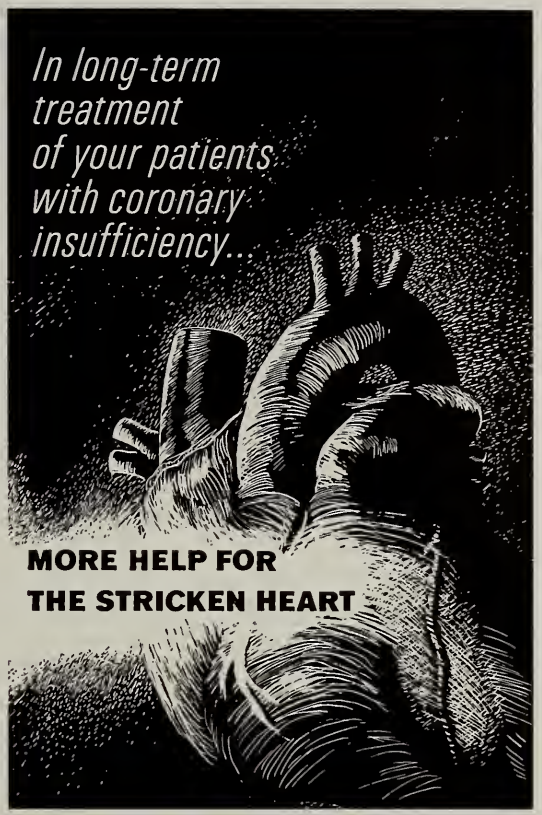
Dr. William A. Hyland of Grand Rapids, Mich. was re-elected to the Council on Constitution and Bylaws. ◄

F. J. L. Blasingame, M.D.
Executive Vice President
American Medical Association

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ABSTRACTS

BOOK REVIEWS

CLINICAL BIOCHEMISTRY

Abraham Cantarow, M.D., Max Trumper, Ph.D. Sixth edition, W. B. Saunders Company, Philadelphia, 1962. 776 pages; 48 tables; 64 figures; $13.00.

This sixth edition of the clinical companion to the regular biochemical textbook continues to deserve its popularity in its particular field. It is well and simply written; it avoids exhaustive discussion; it is easily assimilated by the medical student, resident and busy practicing physician who has forgotten much of what he has studied and who is uncertain of the latest advances in this branch of knowledge.

For these very reasons, it is my thought that the book has some defects susceptible to easy remedy. I think that an appendix which would simply LIST the structural formulas of basic substances participating in the numerous reactions described would be most useful and visually aid the reader. A few reactions written out chemically in the text could help delete a lot of verbiage. Specifically, I liked the handling of steroids by the authors; why not the Krebs cycle—and coenzyme A? And what about chelation?

In spite of such petty queries, the printing is clear, the binding excellent and typographical errors almost non-existent. The authors have continued to revise diligently and give their readers a useful book.

ARNOLD LIEBERMAN, M.D.
New York, N. Y.

TOWARD EARLIER DIAGNOSIS, A FAMILY DOCTOR'S APPROACH

Keith Hodgkin, B.M., B.Ch. (Oxon), M.R.C.P. (Lond), member of M.R.C. Committee for Research in General Practice, E.&S. Livingstone, Ltd., Edinburgh and London, 1963; Williams & Wilkins Co., Baltimore. 447 pages plus index. $6.50.

While this book has a total of 459 pages, it is only 2 cm. thick, and of handbook size, nicely bound in semi-limp plastic covers. It is therefore convenient to carry about for occasional browsing in spare time, its content being well suited to such a purpose. The book is interesting from several points of view, including the art and practice of medicine; the need for the G.P. to make a diagnosis at earlier stages of illness than are usually seen in hospital practice; a method of doing research along this line in general practice, and a means of assistance to young practitioners confronted for the first time by the intensely pragmatic demands of home and office practice. As he states in the preface: "My aim is to describe

in the overweight stable adu

...fasting serum levels of insulin are usually normal, postprandial levels excessive[1-3]

...insulin acts in adipose tissue via hexose monophosphate shunt, principal path of glucose conversion to storage fat[1,4]

...excessive endogenous insulin acts to stimulate lipogenesis and weight gain[1,3,4]



how a family doctor works and thinks."

His data and conclusions are all derived from his own records of illnesses seen by him as a student (three and one half years), intern (24 months), private practice (three years) and one National Health Service practice (10 years). In his N.H.S. practice he had 2,500 patients and he believes that standards fall off after the 2,500 mark is reached.

As a sample of his logical and simple presentation he outlines the technic of helping patients under four headings: "1. *Prediction* of the course that a disease process may follow—called diagnosis and prognosis. 2. *Prevention* of the serious effects of a disease process. 3. *Prescribing* treatment for relief of that which cannot be prevented. 4. *Preparation* of the patient for that which can neither be prevented nor relieved."

The main body of the work is really a report of the author's own experience in making and revising diagnoses. His chief statistics are concerned with the incidence per 1,000 N.H.S. patients per year of the different diagnoses, reported as "Diagnosis suspected" and "Diagnosis confirmed." This method gives valuable insight, at once, into those conditions which give the most difficulty and in which, accordingly, great care must be exercised.

The different systems of the body (and the personality) are presented in separate chapters, first giving "Common problems of recognition" and then "Less common diseases" of each system. For each disease there is a short outline of "Aetiology, Diagnostic Incidence, Age Incidence, Sex Incidence, Clinical Pointers, Investigations (i.e. special tests to be used), Duration, Complications, Misleading Features and Pitfalls and finally Differential Diagnosis." Here he lists "Similar features" and "Distinguishing features" for each disease considered under this heading. In addition to this systematic presentation, there is an appendix describing his office and armamentarium and another showing in detail how he keeps his records. Finally there is an index of all the diseases and conditions discussed in the book.

Dr. Hodgkin has a good style and there are many salty observations scattered through the book. Of course there are occasional statements relative to conditions found in Britain which would not be considered applicable here, but these can serve to give us more insight into life under the N.H.S. Taken for what it is, a detailed report on one man's extensive experience, and not as the last word on any one subject, this is a most interesting and valuable piece of clinical research.

A. W. CAVINS, M.D.,
Terre Haute

THE THYROID AND ITS DISEASES

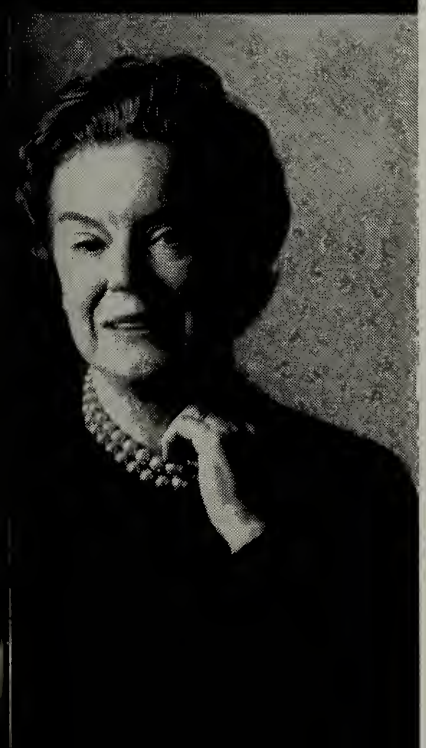
J. H. Means, L. J. DeGroot, J. B. Stanbury. Third edition, McGraw-Hill Company, New York, N. Y., 1963. 618 pages; numerous illustrations; $15.95.

The Thyroid Clinic of the Massachusetts General Hospital has a vast accumulation of material. The

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side effects: Gastrointestinal, occurring more often at higher dosage levels, abate promptly upon dosage reduction or temporary withdrawal. **precautions:** Occasionally an insulin-dependent patient will show "starvation" ketosis (acetonuria without hyperglycemia) which must be differentiated from "insulin-lack" ketosis which is accompanied by acidosis, and treated accordingly. Lactic acidosis has been reported in non-diabetics and diabetics treated with insulin, with diet, and with DBI. Question has arisen regarding possible contribution of DBI to lactic acidosis in patients with renal impairment and azotemia and also those with severe hypotension secondary to myocardial or bowel infarction. Periodic B.U.N. determinations should be made when DBI is administered in the presence of chronic renal disease. DBI should not be used when there is significant azotemia. Any cardiovascular lesion that could result in severe or sustained hypotension, which may itself lead to development of lactic acidosis, should be considered cause for immediate discontinuation of DBI at least until normal blood pressure has been restored and is maintained without vasopressors. Should lactic acidosis occur from any cause, vigorous attempts should be made to correct circulatory collapse, tissue hypoxia, and pH. **contraindications:** Severe hepatic disease, renal disease with uremia, cardiovascular collapse. Not recommended without insulin in acute complications of diabetes (metabolic acidosis, coma, severe infections, gangrene, surgery). **pregnancy warning:** *During pregnancy, until safety is proved, use of DBI, like other oral hypoglycemic drugs, is to be avoided.* Consult product brochure for full information.

1. Gordon, E.S.: Metabolism 11:819, 1962. 2. Grodsky, G.M. et al.: Metabolism 12:278, 1963. 3. Weller, C. et al.: Scientific Exhibit, A.M.A., June 1962. 4. Sadow, H.S.: Metabolism 12:333, 1963. 5. Faludi, G.: J. Am. Med. Women's Assoc. 18:722, 1963. 6. Faludi, G.: Geriatrics 18:452, 1963. 7. Williams, R.H.: Textbook of Endocrinology, Ed. 3, Saunders, Phila., 1962, p. 610. 8. Weller, C. and Linder, M.: Am. Therap. Soc., June 1963. 9. Moss, J.M. et al.: Med. Times, July 1964.

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CONTRAINDICATION: Anuria.



1. Steigmann, F., and Griffin, R.: Evaluation of Quinethazone, a New Diuretic. *J. Amer. Geriat. Soc.* 11:945 (Oct.) 1963.
2. Schwartz, M.: Office Evaluation of a New Diuretic in Patients with Hypertensive Diseases. Scientific Exhibit Presented at the Clinical Meeting of the American Medical Association, Los Angeles, California, Nov. 25-28, 1962.

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authors of the present monograph have made full use of their experience. They also have drawn on the literature and attempted a critical judgment while avoiding being didactic or even pedantic.

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There are longer monographs, as Werner's; there are much shorter volumes, as Trotter's. On the whole, the authors have aimed at the serious graduate student, internist and others interested in the workings of the thyroid gland. In a highly competitive field, they have succeeded well. The publisher has furnished excellent printing, binding and illustrating. All-in-all, this edition maintains its standing as a classic in its domain.

ARNOLD LIEBERMAN, M.D.
New York, N. Y.

Abstracts From Various Literature, Prepared by AMA

GASTROINTESTINAL BLEEDING OF "UNKNOWN ORIGIN"

D. Brayton (1216 Wilshire Blvd., Los Angeles), *Amer. J. Dis. Child.* 107:287 (March) 1964

Gastrointestinal hemorrhage in the pediatric age group, particularly that of rectal issue, is studied by comparison of three case series, including 48 cases of bleeding Meckel's diverticulum, 16 cases of peptic ulcer and 79 cases of bleeding due to "unknown cause." The mathematical probability of finding a Meckel's diverticulum at laparotomy for rectal bleeding is calculated for this series, and the rate of diagnostic accuracy is found to be less than 66%. The probabilities of origin of hemorrhage in the "unknown bleeder" are discussed. The conclusion is reached that larger numbers of such cases than heretofore realized are probably because of acute peptic ulceration of the stomach or of the duodenum. Certain clinical recommendations are made based upon this hypothesis.

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EMERGENCY TREATMENT OF HYPERKALEMIA

M. J. Chamberlain (Medical Unit, Westminster Hosp. London) *Lancet* 1:464 (Feb. 29) 1964.

The intravenous injection of calcium is advocated as the treatment of choice in the emergency management of extreme hyperkalemia. The physiological basis of its action is discussed. Five illustrative case reports with electrocardiograms are presented.

THE ADVISABILITY OF INCIDENTAL APPENDECTOMY IN THE PRESENCE OF REGIONAL ENTERITIS

F. W. Marx, Jr. (University of California Medical Center, Los Angeles) *Arch. Surg.* 88:546 (April) 1964.

Patients with regional enteritis often have signs and symptoms which are clinically indistinguishable from acute appendicitis. Although exploration is mandatory, disagreement exists whether or not incidental appendectomy should be done because of the high incidence of patients with fistulae and intra-abdominal abscesses. In the nine cases seen, no such postoperative complications followed appendectomy, and in 12 cases referred with complications following appendectomy, the source of fistulae or abcesses was never the appendicular stump, but the diseased small bowel. If the cecum is not involved with regional enteritis, incidental appendectomy is recommended.

CARCINOMA OF THE COLON IN ULCERATIVE COLITIS

M. B. Goldgraber, J. B. Kirsner (950 E. 59th St., Chicago) *Cancer* 17:657 (May), 1964.

Carcinoma of the colon is significantly more common in patients with chronic ulcerative colitis than in the general population. The colonic carcinoma occurs at an earlier age, is distributed more uniformly throughout the bowel, and often is multifocal in origin and highly malignant, although prolonged survival is not unusual after resection of the lesion. The diagnosis of colonic carcinoma in ulcerative colitis is difficult, but is attainable by frequent clinical and laboratory observation of the patient, repeated proctoscopic examinations, and judicious roentgenologic and cytological studies of the colon and rectum. ◄

The Journal Welcomes New ISMA Members

Anna Brand, M.D., *General Practice,* Universite de Nancy, France, 1937. (Lake)

Virgil A. Beuerman, M.D., *Ophthalmology,* University of Iowa, 1940. (Tippecanoe)

Joan E. Doan, M.D., *General Practice,* Cincinnati University, 1961. (Adams)

Robert P. Inlow, M.D., *General Surgery,* Indiana University, 1956. (Shelby)

Carl E. Rutledge, M.D., *Pathology,* University of Louisville, 1955. (Wells)

Marvin C. Schneider, M.D., *General Practice,* Indiana University, 1962. (Rush)

John R. Thompson, M.D., *Surgery,* University of Michigan, 1944. (Grant) ◄

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Medicine At Law

DECISIONS AND OPINIONS

Highlights of recent court actions pertaining to health and medicine from *The Citation* prepared by the Law Division of AMA.

Supreme Court Rules Union May Refer Members to Attorneys—A union may lawfully advise injured workers not to settle their claims without consulting an attorney and it may recommend a specific attorney. A majority of the U. S. Supreme Court ruled that a state law prohibiting such activity was an unconstitutional interference with the rights of the union members to freedom of speech, petition and assembly under the First and Fourteenth Amendments.

This union activity had been enjoined by a state court on the ground that it amounted to unlawful solicitation of clients for attorneys and unauthorized practice of law. The union selected and approved 16 regional attorneys. Its representatives contacted injured workmen and advised them not to settle their claims before consulting an attorney. They also recommended the appropriate regional attorney and advised the workmen that this attorney was the only one approved by the union in the region. It was admitted by the union that the effect of this activity was to channel legal employment to these particular attorneys.

Justice Clark dissented vigorously, stating that the activity of the union contravenes both the accepted ethics of the legal profession and the statutory and judicial rules of accepted conduct. He also said that the majority decision relegates the practice of law to the level of a commercial enterprise. Justice Harlan joined in the dissent.

Brotherhood of Railroad Trainmen v. Virginia, 84 S. Ct. 1113 (U.S., Apr. 20, 1964).

Citation Editor's Note: Although this decision would appear to apply equally to medical societies, wisdom might indicate that they do not follow the lead of the labor unions. Physicians would be well advised to support the ethical standards of the sister profession of law. Maintenance of high professional standards, including prohibitions against third-party interference, is essential for the preservation of the professional status of all professions.

Evidence Raises Jury Question as to Informed Consent to Operation—A doctor may be liable for failure to adequately warn parents of the risks of a medical procedure on a child patient. A directed verdict in favor of the doctor in a malpractice action arising out of the performance of an arteriogram was reversed and the case remanded for a new trial by a Florida intermediate appellate court.

After examining the patient, a nine-year-old boy who suffered from spells (seeing things, etc.), the doctor, a neurologist, was in doubt as to whether the trouble was organic or emotional. The doctor recommended an exploratory arteriogram, rather than having the boy undergo psychiatric treatment. The parents consented to the procedure. The arteriogram resulted in partial paralysis of the patient.

Unless the parents knew the dangers and the degree thereof to be anticipated in the performance of an arteriogram, their consent to the procedure was not an informed consent and was, therefore, ineffectual. The doctor had a duty to adequately inform the patient's parents of the possible dangers of the procedure and not to minimize the

fact that three percent of arteriograms were known to result in death, paralysis or other injurious outcome, the court said. There were conflicts in the evidence as to whether the doctor complied with his duty of fully informing the parents which presented a question for jury determination, the court ruled.

The procedure was performed by a second doctor. There was a verdict in favor of the second doctor in the trial court. However, that verdict did not relieve the first doctor of liability because the bases for liability or nonliability were not the same for both doctors, the court said.

Bowers v. Talmage, 159 So. 2d 888 (Fla., Dec. 3, 1963; rehearing denied, Feb. 12, 1964).

Doctor Permitted to Treat Child Patient Despite Agreement not to Practice—Two doctors practicing in partnership were ordered not to interfere with a third doctor, a former partner, in his treatment of a child patient, despite his agreement not to practice in the area involved.

Under the partnership arrangement, the doctor had agreed that if he left the partnership he would not, under penalty of a $10,000 damage clause, practice medicine for three years within an 18-mile radius of the town of Lemont, Illinois. After he left the partnership to practice in Chicago, he continued to treat a child patient in Lemont, at the request of her parents.

The child had chronic and acute bronchial asthma, bronchostenosis and chronic recurrent pneumonitis. She was confined to her home and received her school instruction through an electronic system installed by the telephone company. After the doctor left the partnership, the child was treated by the other partners, but the parents were dissatisfied with the results. They felt that her condition could be treated satisfactorily only by the third doctor.

Since it impaired the child's health to travel from her home, the parents requested permission of the partners to have the third doctor treat her in Lemont. The partners refused their permission, however, and threatened the third doctor with an action to recover $10,000 damages if he continued to treat the patient.

The parents then sought a temporary injunction restraining the partners from interfering with the doctor's treatment of their daughter at home. The court granted the injunction without opinion.

In a suit pending before the court, the doctor is seeking to determine his rights with respect to his former partners. The suit asks a determination of whether the covenant not to practice is an undue restraint of trade and whether the partnership dissolution agreement is valid.

Zinngrabe v. Brown and Clark, Cir. Ct., Cook Co., Case No. 64 CH 1422 (Ill., March 30, 1964).

Medical Schools' Refusal of Bequest of Body Nullifies Accompanying Request for no Funeral Services—When the two named medical schools declined the bequest of the decedent's body for use in experimentation in the interest of medical science, the wishes of her family took precedence over the administrator of her estate with respect to her direction, contained in the same clause of the will as the bequest of her body, that no funeral services be held for her, the New Hampshire Supreme Court ruled.

Ordinarily, a decedent's instructions, by will or otherwise, as to the disposition of his body or funeral services or burial should be respected and followed in preference to the opposing wishes of his survivors. The decedent's request in her will that no funeral services be conducted for her was coupled in one clause with her attempted donation of her body for scientific uses. Since the decedent's primary purpose failed, as the result of the medical schools' refusal to accept her body, it was not unreasonable to conclude that the wishes of her family should take precedence. It was, therefore, not an abuse of discretion to permit the brief and simple funeral services proposed by her family, the court said.

Holland v. Metalious, 198 A. 2d 654 (N.H., March 18, 1964). ◄

1964 Instructional Courses

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The schedule of classes for the 1964 Instructional Courses, offered as a special feature of the Annual Convention of the Indiana State Medical Association at Indianapolis, is published below. Classes will be held on Wednesday morning, October 14, 1964, from 9:30 to 11:30.

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Wednesday, October 14, 1964

COURSE NUMBER		
1	9:30-10:30	*"Office Control of Long Term Anticoagulant Therapy,"* RICHARD P. GRIPE, M.D., Lafayette
2	9:30-10:30	*"Significant Factors in the Differential Diagnosis of Common Rheumatic Diseases,"* FRED H. PRIEBE, M.D., Indianapolis
3	9:30-10:30	*"Competitive Sports for the School Age Child,"* EDWARD A. TYLER, M.D., Indianapolis
4	9:30-10:30	*"A Practical Approach to the Treatment of Chronic Broncho Obstructive Disease,"* JOSEPH ROSS, M.D., Indianapolis
5	9:30-10:30	*"Acute Tubular Necrosis: Diagnosis and Therapy,"* GEORGE T. LUKEMEYER, M.D., Indianapolis
6	9:30-10:30	*"Office Gynecology,"* RICHARD J. SHELLEY, M.D., Indianapolis,
7	10:30-11:30	*"Surgical Emergencies of the Chest,"* GEORGE D. BUCKNER, M.D., Fort Wayne
8	10:30-11:30	*"Cutaneous Reactions in Diabetes Mellitus,"* VICTOR C. HACKNEY, M.D., Indianapolis
9	10:30-11:30	*"Recognition and Treatment of Common Arrhythmias,"* JOHN F. LING, M.D., Richmond
10	10:30-11:30	*"Selection of Treatment in Hyperthyroidism,"* GLENN W. IRWIN, Jr., M.D., Indianapolis
11	10:30-11:30	*"Common Anorectal Disorders,"* RAY H. BURNIKEL, M.D., Evansville HERMAN C. SPRECHER, M.D., Evansville
12	10:30-11:30	*"Pulmonary Disease in Childhood,"* SAM GIAMMONA, M.D., Indianapolis

Application blank at top of next page.

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Eugene P. O'Donnell, E. W. Sparrow Hospital, Lansing, Mich.

SPECIALISTS

Richard J. Snyder, 301-D 1st Division Road, Fort Benning, Ga.—*Ob-Gyn*

Dana S. Newton, 530 El Camino Real, Burlingame, Calif.—*Ophthalmology*

Russell Noyes, Jr., U. S. Naval Hospital, Great Lakes, Ill.—*Psychiatry*

Joseph R. Chemycz, 4930 Hillcrest Ave., Okemos, Mich.—*Student Health Service, Industrial or Insurance Medicine*

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The Physician's Role in Promoting Blue Shield Growth and Development

(One of a series prepared by Blue Cross-Blue Shield)

(*This article is the second in a two-part series, and includes other excerpts from the presentation made at the* 1964 *Indiana Blue Shield Seminars by Daniel F. Hanley, M.D., Executive Director of the Maine Medical Association*).

Let us discuss utilization: Five different hospitals, each discharging about 1,000 patients in a three-month period, were studied to find out what could be determined regarding unnecessary admissions. A patient who did not stay overnight or did not die could no doubt be considered a diagnostic admission unless proven otherwise. These patients were specifically tabulated and identified in reports from these five hospitals. Four of these hospitals had between one and four such admissions. They were patients suspected of appendicitis, psychiatric patients soon to be transferred, patients requiring short-term observation and so forth. However, in the fifth hospital there were 23 cases, six times as many. Of these, five patients had ailments similar to those of patients in the other four hospitals. The remaining 18 patients were clearly admissions of convenience, and almost all of them were under the care of a single physician.

Whose responsibility is it to educate him?

In utilization, again, there is another area easily measured, namely overstay and short illness. A tonsillectomy and adenoid operation ordinarily requires only a brief hospital stay, but the method of utilizing hospitals for T&A's varies tremendously from area to area, and among the hospitals and doctors in the same area. Some doctors hold T&A patients for only 48 hours. Other T&A patients are routinely held for five or six days and these are *uncomplicated* cases.

Whose responsibility is this and what does this over-utilization do to the growth and the development of voluntary programs?

There is a wide variance among physicians in their use of hospital beds and the tendency to slough off the cause of over-utilization on the patient may not stand up in the light of statistical analysis.

The same sort of study has been done on obstetrical cases with exactly the same results.

The practice of medicine is an individual art, but sometimes the individuals who practice this art do it to the detriment of the group. When this occurs, who has the responsibility of educating these individuals? Whose responsibility is it to put out the "cease and desist" order?

These are questions you will have to answer if voluntary or any kind of prepayment insurance is going to prosper.

I made some notes on a few utilization cases which I think you will find interesting. One patient could have been sent home after being treated for a small paronychia. Instead, this patient was hospitalized, underwent x-rays in case there was any osteoarthritis, had lab work done to rule out diabetes and each day had culture and sensitivity tests performed. This may be ideal medicine from a professor's point of view, but not from a health insurance point of view.

We had another case of simple, uncomplicated, pneumonia that had so many x-rays I think the doctor was trying to treat it by radiation therapy.

The percentage of the public's disposable income devoted to medical care has risen 40% in the last 10 years and medical care itself equals seven percent of the total cost of living for the average American family. These figures are all meaningful, and some of them are even a little startling, but they become more meaningful and much more startling when we realize that the insured population has two times the hospital admission rate of the uninsured population and the main difference appears to be in surgical procedures.

We have been, and are still, anxious to build bigger and better medical facilities, but we have not yet learned ourselves or paused to teach our successors how to use them effectively. We are still in the era where the surgeon "saves money" by taking an extra few minutes to tie the last knot with short ends of suture material so the nurse won't have to open a fresh pack. Four or five days later the same surgeon says to the patient, "It's O.K., you can stay in the hospital another four or five days if you feel like it."

Utilization, in general, is a problem for us all, and it is our duty to solve this problem. Physicians cannot evade, nor can they delegate this responsibility to anyone else unless they are willing also to delegate the privileges of self-discipline, self-determination and self-policing.

The well-being of voluntary health plans and the medical profession is so closely woven together that to paraphrase Charlie Wilson, "What is good for Blue Shield is good for medicine."

When a physician exercises his normal responsibility to the patient, when the physician sees the patient gets the best medical care but only when this care is medically indicated and only for the length of time it is indicated, he is exercising his responsibility to Blue Shield and to his community. ◄

Industrial Medicine Data Needed by Dr. Painter

Dr. Lowell Painter, Winchester, is interested in collecting suggestions and advice for an ISMA booklet which would be helpful to the general practitioner who is called upon to practice part-time industrial medicine.

Any member of ISMA experienced in this field, is invited to write Dr. Painter at 124 E. Franklin St., Winchester, Indiana.

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PHYSICIANS CAUTIONED ON X-RAYS OF WOMEN OF REPRODUCTIVE AGE

The International Commission of Radiological Protection has issued a report to call physicians' attention to reports of embryonic and fetal sensitivity to ionizing radiation. The report also emphasizes that the possibility of pregnancy must be taken into account by the attending physician when deciding on radiological examinations that involve the lower abdomen and pelvis of women of reproductive age.

The commission points out that the ten-day interval following the onset of menstruation is the only time when it is virtually certain that women of such age are not pregnant. It is therefore recommended that all radiological examinations of the lower abdomen and pelvis of women of reproductive age, that are not of importance in connection with the immediate illness of the patient, be limited in time to this period when pregnancy is improbable.

The examinations that should be delayed to await the onset of the next menstruation are those that could, without detriment, be delayed till the conclusion of a pregnancy or at least until its latter half.

Dr. Wood Made Clinical Professor

Dr. Donald E. Wood, president of ISMA, has been elevated to clinical professor of medicine at the Indiana University School of Medicine.

Indiana Physicians Named

Drs. Paul G. Dintaman of Indianapolis and Frank M. Steele of Muncie have been elected Fellows of the American College of Physicians. Drs. Raymond L. Newnum, Evansville and James G. Armstrong, Stanley M. Chernish, Walter J. Daly, John D. Graham and Cyrus C. Johnston, Jr., all of Indianapolis, have been elected as Associates of the college.

FILMSTRIP ON PHENYLKETONURIA AVAILABLE TO PHYSICIANS

Mead Johnson Co. has prepared a filmstrip on the subject of phenylketonuria. It is designed for showing to practicing physicians, interns, residents and dietitians.

The film may be obtained by writing Project Director, Medical Affairs, Mead Johnson & Co., 2404 Pennsylvania St., Evansville 47721.

Dr. Kilgore's Daughter Wins Award

Diane Kilgore, a sophomore at Fort Wayne Northside High and daughter of Dr. Byron Kilgore, won the Allen County Mental Health Association award for her design for a plaque to be awarded to outstanding volunteers in the Mental Health field. She also won honorable mention on the state level. Her ingenious design was called the Key of Hope and stressed love, education and industry as desirable traits in volunteers.

New Diabetes Film Available

A new motion picture, "Diabetes—What You Don't Know Can Hurt You" has been produced by Ames Company of Elkhart in cooperation with the Joslin Clinic.

It is a 16 mm., color, sound film and runs for 27 minutes. It is suitable for physicians, nurses and lay groups. The film may be obtained by writing Ames Film Department at Elkhart.

Dr. Bondurant Named Editor

Dr. Stuart O. Bondurant, Indianapolis, has been appointed the new editor of *Clinical Research*, the official publication of the American Federation for Clinical Research. He succeeds Dr. Morton Bogdonoff, editor for the past five years, who this year becomes the federation's president.

Emerson A. North Hospital Celebrates 90th Anniversary

The Emerson A. North Hospital, oldest private psychiatric hospital west of the Alleghenies, is celebrating its 90th year.

Located just outside Cincinnati, it was originally designated as The Cincinnati Sanitarium when founded in 1874. Later it was renamed to honor Dr. North who was its chief psychiatrist and administrator for many years.

Subject Announced for Caleb Fiske Medical Essay

The trustees of America's oldest medical essay competition, the Caleb Fiske Prize Essay of the Rhode Island Medical Society, announce "Recent Advances in the Control of Respiratory Virus

Diseases, Including the Exanthemata" as the subject for this year's dissertation. The essay must be typewritten, double spaced, and should not exceed 10,000 words. A cash prize of $500 is offered. Essays must be submitted by December 11, 1964.

For complete information regarding the regulations write to the secretary, Caleb Fiske Fund, Rhode Island Medical Society, 106 Francis St., Providence, Rhode Island 02903.

Indiana Doctors Certified

The American Board of Obstetrics and Gynecology announces the certification of five Indiana physicians. There are Drs. William A. Karsell and John W. Armstead, Indianapolis; Dr. Kenneth G. Lansford, LaPorte; Dr. Donald L. Bebensee, South Bend and Dr. Charles F. Abell, Jr., of Marion.

Deafness Research Foundation Named Grant Recipient

The Deafness Research Foundation is the recipient of a grant of more than a quarter million dollars, the largest ever made for ear research, by the Alfred P. Sloan Foundation. The funds will be expended in the next two years and will be applied to research projects in otologic laboratories and medical schools in the United States. A committee of leading researchers will make recommendations.

Ralph J. McQuiston, M.D., Indianapolis otolaryngologist has been appointed Indiana state chairman of the foundation.

As state chairman, Dr. McQuiston will act as spokesman for DRF at state and regional medical meetings, serve as liaison between the Foundation, the medical profession and the general public, and reply to inquiries about medical aspects of ear disorders addressed to the Foundation by people in Indiana.

American Heart Association Accepting Applications for Investigatorships

The American Heart Association is now accepting applications from research investigators for support of studies to be conducted during the fiscal year beginning July 1, 1965.

September 15, 1964 is the deadline for submitting applications for established investigatorships and advanced research fellowships.

Applications for grants-in-aid should be submitted by November 1, 1964. Grants-in-aid are made to experienced investigators to help underwrite the costs of specified projects, such as equipment, technical assistance and supplies.

Further information and application forms for research awards may be obtained from the Director of Research, American Heart Association, 44 E. 23rd St., New York, N. Y. 10010.

SKF Representative Promoted

Mr. Thomas M. Bushold, a Smith Kline & French hospital service representative for the Indianapolis area has been promoted and will work as Scientific Employment Administrator in the Philadelphia headquarters of SKF.





DOCTOR DONALD E. WOOD (right) president of the Indiana State Medical Association, and Doctor Lester Bibler, Indianapolis, member of the Board of Trustees of the American Medical Association, display the award which was made in Washington D.C. in April to Elmer C. Paul, former lieutenant of the Indiana State Police Department. Paul was cited by ISMA and the AMA for initiating automobile crash-injury research in 1949, in cooperation with ISMA. This beginning has led to research projects throughout the nation over the past 15 years which have led to the incorporation and periodic changes in automobile safety features, including the seat belt, the padded dash and the safety door lock.

Mead Johnson Names Award Winners

Mead Johnson and Company has announced the 1964 Mead Johnson awards for graduate training in anesthesiology.

Dr. William C. Dwyer of Syracuse, New York; Dr. Michael T. Pappas of Pittsburgh and Dr. David K. Ricks of Salt Lake City received the scholarships which will enable them to complete residency training.

Psychiatry Society Elects

Dr. August J. Dian, Gary, has been installed president of the Northern Indiana Psychiatric Society.

Other new officers are: Drs. L. D. Borough, South Bend, president-elect; Hans Meyer, Westville, vice-president; R. L. Shriner, South Bend, treasurer and J. R. Matthew, Westville, secretary. ◄

INDIANA STATE BOARD OF HEALTH

MONTHLY REPORT — June, 1964

Disease	June 1964	May 1964	Apr. 1964	June 1963	June 1962
Animal Bites	1139	1068	904	1036	948
Chickenpox	203	483	723	244	195
Conjunctivitis	173	142	207	46	69
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	65	45	71	70	6
Gonorrhea	322	325	312	245	Not Available
Impetigo	130	69	146	63	85
Infectious Hepatitis	39	35	71	40	64
Infectious Mononucleosis	58	62	97	21	15
Influenza	120	202	506	88	182
Measles (Rubeola-Rubella)	2358	5019	6868	377	618
Meningitis, Meningococcal	2	2	9	5	2
Meningitis, Other	4	7	9	4	2
Mumps	467	751	1422	244	132
Pertussis	52	41	53	29	47
Pneumonia	173	200	344	85	106
Poliomyelitis	0	0	0	1	0
Streptococcal Infections	433	468	903	241	248
Syphilis					
Primary & Secondary	5	1	6	7	Not Available
All Other Syphilis	102	98	105	103	Not Available
Tinea Capitis	9	14	27	2	5
Tuberculosis (Active)	90	101	169	107	93

SCIENTIFIC EXHIBIT APPLICATION FORM

Committee on Scientific Exhibits
Indiana State Medical Association
3935 N. Meridian Street
Indianapolis 8, Indiana

Please send me an application form for a Scientific Exhibit at the ISMA Annual Convention, October 13-15, 1964, Murat Temple, Indianapolis, Indiana.

I propose to exhibit_____

Name_____

Address_____

City_____

State_____

FUTURE MEETINGS, SEMINARS, COURSES

Marion County General Hospital To Conduct Postgraduate Courses

The Marion County General Hospital will conduct four postgraduate courses during the coming academic year. Each of the one-day courses has been approved by the American Academy of General Practice.

"Diagnosis and Management of the Hypertensive Patient" will be September 30, 1964; "Infectious Diseases" will be November 18, 1964; "Management of Common Arthritides" will be held on January 27, 1965; "Common Problems of Pulmonary Diseases" will be on March 24, 1965.

Drs. Bill Martz, Richard Griffith, Fred Priebe and John Miller will be course directors.

All physicians in Indiana will receive detailed descriptions of the courses and notification of the lecturers by mail at a later date.

Annual Cancer Symposium Set for September 23 at I.U.

The annual Cancer Symposium will be held at Indiana University Medical Center on Wednesday, September 23. A full day's program will be devoted to lectures and panel discussions on the subject of "Cancers of the Head and Neck."

The Schools of Medicine and Dentistry, ISMA and the Indiana Academy of General Practice are cooperating with the American Cancer Society in sponsoring the meeting.

American College of Surgeons Annual Fall Meeting October 8-10

The American College of Physicians will hold its second annual fall meeting October 8 to 10 at the Biltmore Hotel in Los Angeles.

Complete information may be obtained by writing Dr. Edward C. Rosenow, Jr., 4200 Pine St., Philadelphia.

American Heart Association Sets Annual Scientific Session

The American Heart Association's annual Scientific Session will be held in Atlantic City October 23 through the 25th. An all-day session on stroke, Saturday the 24th, will cover aspects of special interest to the general practitioner, from prevention through long-term convalescent care.

Panels, lectures and symposia will be presented on the clinical aspects of cardiovascular disease. Registration forms and hotel reservation cards may be obtained from the Indiana Heart Association, 615 N. Alabama St., Indianapolis.

Cleveland Clinic Lists Postgraduate Course for September 30-October 1

The Cleveland Clinic will present a postgraduate course on "Diseases of the Esophagus, Stomach and Duodenum" September 30 and October 1.

The course will be presented by staff members of the Cleveland Clinic Foundation assisted by several guest speakers. Registration fee for the course is $30.00. Interested physicians should write to the Education Secretary, Cleveland Clinic Educational Foundation, 2020 E. 93rd St., Cleveland 44106.

Rhode Island Medical Society to Review Medical Aspects of Sports

Medical Aspects of Sports will be reviewed in a Postgraduate Conference August 20 and 21, at Kingston, Rhode Island. This is the third such conference and is held with the cooperation of the University of Rhode Island and the Rhode Island Medical Society.

Registration fee is $30.00. Fifteen credit hours is given for the course by the Academy of General Practice. The faculty will consist of prominent athletic coaches, trainers and team physicians. For more details write Rhode Island Medical Society, 106 Francis St., Providence, R. I. 02903. ◄

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Deaths

Oren E. Carter, M.D.

Dr. Oren E. Carter, 69, a specialist in internal medicine, died June 20 at Indianapolis.

Dr. Carter, a graduate of Northwestern University Medical School, opened his office in Indianapolis in 1926 and continued his practice until April of this year. A staff member at Methodist and St. Vincent's Hospitals, Dr. Carter served in World War I and was a member of the Marion County Medical Society.

Paul E. Merrell, M.D.

Dr. Paul E. Merrell, Indianapolis neurological surgeon, died May 20 in Methodist Hospital. He was 64.

A graduate of the University of Cincinnati Medical School, Dr. Merrell was chairman of the neurosurgery section of General Hospital; consultant in neurosurgery at Marion County Tuberculosis Hospital at Sunnyside and a staff member of Methodist, St. Vincent's, General, Community and St. Francis Hospitals and the Indiana University Medical Center. He was also a member of the Marion County Medical Society and many other medical organizations.

T. W. Omstead, M.D.

Dr. T. W. Omstead, 64, of Huntington, died June 24 in St. Joseph's Hospital in Fort Wayne where he had been a patient since June.

Dr. Omstead, a graduate of the I. U. School of Medicine, had practiced in Huntington for 14 years. He served in the Medical Corps in both World War I and II, and was a member of the Huntington County Medical Society, had been Huntington County health officer and was on the staff of the Huntington County Hospital.

Oran A. Province, M.D.

Dr. Oran A. Province, Franklin physician for 55 years, died June 14 at the age of 87.

Dr. Province, a graduate of the College of Physicians and Surgeons of Columbia University, was a member of a family of physicians and surgeons which has served Johnson County for 93 years. Dr. Province was the attending physician and surgeon for the Masonic Home at Franklin since 1915, the year it was built.

Dr. Province was a member and past president of the Johnson County Medical Society; past president of the Seventh District and a member of ISMA's scientific program committee for eight years.

Earl M. Shenk, M.D.

Dr. Earl M. Shenk, 78, member of the ISMA 50-Year Club and the Howard County Medical Society, died May 26. He was 78. ◄

WABASH VALLEY HOSPITAL

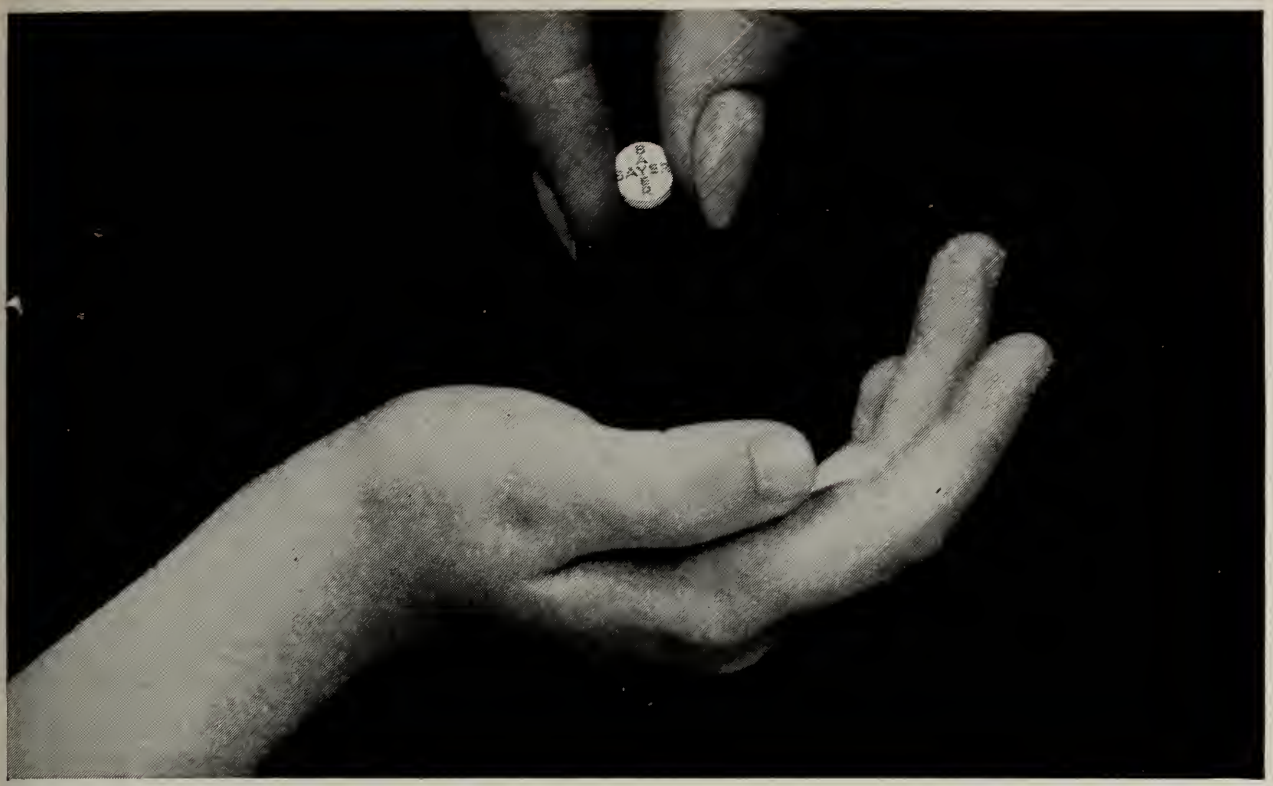
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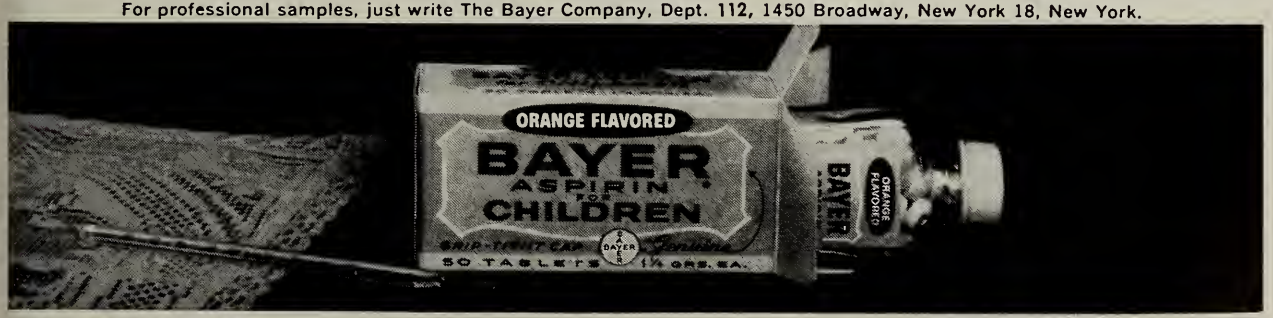


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SEPTEMBER 1964

The Journal
of the INDIANA STATE MEDICAL ASSOCIATION

Office of Publication
3935 N. Meridian, Indianapolis, Indiana

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EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members. Cost of color illustrations must be shared by the author.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible. However, the right is reserved to reduce in length or reject any article.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication in THE JOURNAL of the Indiana State Medical Association.

Communications dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 1802 North Illinois Street, Indianapolis 2, Indiana. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 3935 N. Meridian, Indianapolis 8.

Advertising rates will be furnished on request. Copy must be received by the 5th of the month preceding month of issue. (Scientific manuscripts must be received at least two weeks earlier if geared for a specific issue.)

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About Our Cover
on page 959.



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The high rate of response to Signemycin in these cases is noteworthy because the totals include many patients with difficult-to-treat infections, many whose infections had proved resistant to other agents, and many who had been treatment failures on other therapy.[1-87] In addition the following criteria were used for the cases cited: (1) only published results were used (2) results were confirmed by clinical and/or laboratory findings (3) patients were cured, not "improved" (4) dosage conformed with current recommendations in the United States (5) no other anti-infective agents were used concomitantly (6) no instance of prophylactic use was included in these tabulations.

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Gastrointestinal infections	425	387
Genitourinary infections	748	684
Skin and soft-tissue infections	1,088	1,036
Bone and joint infections	71	64
Deep-seated or generalized infections	257	251
Obstetrical & gynecological infections	341	320
Miscellaneous conditions	592	570
Totals	5,057	4,731 (93.5%)

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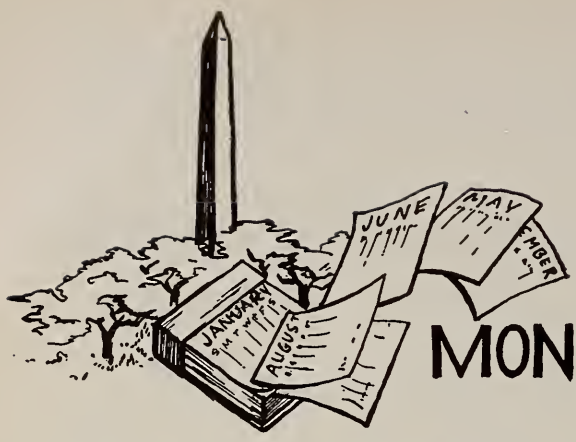
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This summary of what is happening in Washington is prepared by A.M.A.'s Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

MONTH IN WASHINGTON

WASTINGTON, D. C.—Congress for the first time has authorized funds for modernization and renovation of hospitals.

The modernization and renovation program was included in legislation that extends the Hill-Burton hospital construction program for five more years. The legislation easily won approval in both the House and Senate.

The extension provides $840 million for construction of hospitals and public health centers and for the modernization of health facilities.

Of that amount, $680 million is designated for construction and $160 million for modernization with a provision that up to $350 million of the construction funds can be switched to modernization if a state deems it preferable.

The new law also provides:

—$350 million for construction of long-term facilities, including nursing homes and chronic disease hospitals.

—$100 million for construction of diagnostic or treatment centers.

—$50 million for construction of rehabilitation facilities.

—$7.5 million in matching grants for areawide health facility planning in metropolitan and other areas. Under this project, states can use up to two percent of their allotment to improve state administration of the construction program.

FDA ORDERS RELABELING OF DRUGS CONTAINING PHENACETIN

The Food and Drug Administration has ordered that drugs containing phenacetin (acetophenetidin) be relabeled to bear a warning against kidney damage. The order becomes effective Oct. 6, 1964.

The new labeling follows:

"Warning—This medication may damage the kidneys when used in large amounts or for a long period of time. Do not take more than the recommended dosage, nor take regularly for longer than 10 days without consulting your physician."

The labeling change was based on a report by a special advisory committee which concluded after a study of the pain-relieving drug that there is probable cause to conclude that misuse and prolonged use of the drug have been responsible for kidney lesions and disease.

The FDA also has banned and seized a number of "sustained action" or "time disintegration" cold capsules on charges of false claims. The agency said that the products are manufactured by only a few firms for distribution under more than 100 private brand names.

The over-the-counter products are generally labeled as providing up to 12 hours of continuous relief of excessive nasal discharge, running nose,

Continued



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Dosage and administration: Oral – 10 to 20 mg. (1 to 2 tablets) t.i.d. or q.i.d.; I.M. – 5 to 10 mg. b.i.d. or t.i.d. *Contraindications:* There are no known contraindications to oral administration of VASODĪLAN in recommended doses. *Cautions:* VASODĪLAN should not be given immediately postpartum or in the presence of arterial bleeding. Parenteral administration is not recommended in the presence of hypotension or tachycardia. Intravenous administration is not recommended because of the increased likelihood of side effects. *Side effects:* Few side effects occur when given in recommended oral doses. Occasional palpitation and dizziness can usually be controlled by dosage adjustment. Single intramuscular doses of 10 mg. or more may result in hypotension or tachycardia. *Supplied:* 10 mg. tablets in bottles of 100 and 1,000; in 2 cc. ampuls containing 10 mg. (5 mg./cc.) for intramuscular use, boxes of 6. For complete details on indications, dosage, administration, and clinical background of VASODĪLAN, see the brochure of this product available on request from Mead Johnson Laboratories, Evansville, Indiana, 47721.

References: (1) Clarkson, I. S., and Le Pere, D. M.: Angiology *11*:190-192 (June) 1960. (2) Kaindl, F.; Samuels, S. S.; Selman, D., and Shaftel, H.: Angiology *10*:185-192 (Aug.) 1959. (3) Kaindl, F.; Pärtan, J., and Polsterer, P.: Wien. klin. Wchnschr. *68*:186-191 (March 16) 1956. (4) Billiottet, J., and Ferrand, J.: Semaine méd. *34*:635-637 (May 20) 1958.

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watering of the eyes, swelling of the nasal tissues and stuffy congested feeling caused by the common cold and hay fever, the FDA said.

Dr. Joseph F. Sadusk, Jr., FDA Medical Director, said the seized products contain too little of active ingredients to be effective over a 12-hour period. Should a capsule contain an effective dose for a 12-hour period, he said, "a new drug" approval would be required to assure safety and efficacy.

PUBLIC HEALTH SERVICE APPROVES STRENGTHENING OF FLU VACCINES

The Public Health Service has approved the strengthening of influenza vaccines and is again urging that the so-called "high-risks" groups be inoculated against the respiratory disease—between September 1 and December 15 of this year.

The PHS acted upon the recommendations of the special committee on immunization practices which reported that flu vaccines had been shown "in repeated control trials to confer a substantial protection (60 to 80%)."

The incorporation of recent A_2 and B isolates in the 1963-64 vaccine and the increase in their concentration during 1964-65 should result in a vaccine capable of conferring substantial protection in 1964-65, the committee said. It was pointed out, however, that as yet there has been no opportunity to evaluate the newly constituted vaccine under conditions of a natural challenge.

The committee foresaw no major influenza outbreak in the United States this year but recommended inoculation since there is always a possibility of local outbreaks.

The committee recommended that immunization should be considered and generally recommended for persons in groups who experience high mortality from epidemic influenza. The committee said such groups include:

"a) Persons at all ages who suffer from chronic debilitating disease, e.g., chronic cardiovascular, pulmonary, renal or metabolic disorders; in particular:
 "1. Patients with rheumatic heart disease, especially those with mitral stenosis (abnormal narrowing of one of the heart valves).
 "2. Patients with other cardiovascular disorders such as arteriosclerotic heart disease and hypertension, especially those with evidence of frank or incipient cardiac insufficiency.
 "3. Patients with chronic bronchopulmonary disease, for example, chronic asthma, bronchitis, bronchiectasis (degeneration and inflammation of the bronchial tubes), pulmonary fibrosis (scarring), pulmonary emphysema and pulmonary tuberculosis.
 "4. Patients with diabetes mellitus (the common form) and Addison's disease (caused by malfunction of the adrenal glands).

"b) Persons in older age groups. During three successive recent epidemics a moderate increase in mortality has been demonstrated among persons over 45 years and a marked increase among those over 65 years of age.

"c) Pregnant women – It is to be noted that some increased mortality was observed among pregnant women during the 1957-58 influenza A_2 epidemic both in this country and abroad. It has not, however, been demonstrated in subsequent years." ◄

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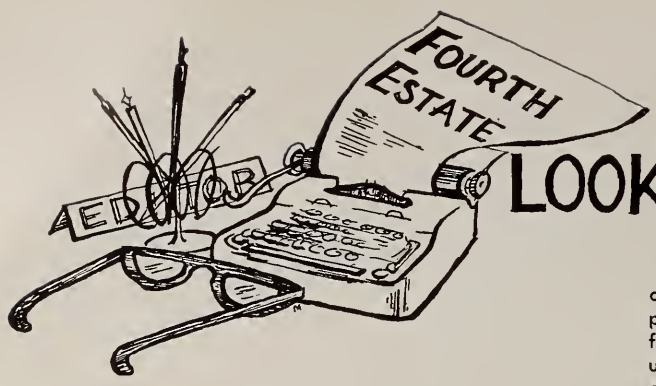
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Side effects: Slight drowsiness and, rarely, allergic or idiosyncratic reactions, due to meprobamate, and occasional dizziness or feeling of depersonalization in higher dosage, due to benactyzine, may occur. **Contraindications:** Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use of meprobamate or meprobamate-containing drugs. **Precautions:** Should administration of meprobamate cause drowsiness, the dose should be reduced. Operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Although suicides with 'Deprol' have not been reported, prescribe cautiously and in small quantities to patients with suicidal tendencies. Massive overdosage of meprobamate may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Even though it has not been reported with 'Deprol', consider the possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage. *Complete product information available in the product package, and to physicians on request.*

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LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Kill Flies With A Shotgun?

The proposal of President Johnson to finance medical care for the aged through social security tax increases is like trying to kill a fly with a shotgun.

This would be the most expensive and least efficient way to aid the older people who cannot afford medical care. Based on 1963 reported tax collections the President's proposal would cost $3,460,200,000 *more* in social security taxes. It would duplicate many state-Federal medical programs already in existence and would duplicate also the millions of private medical insurance programs already in effect among the elderly citizens of this country. It would provide medical care for millions of people who don't need government assistance. And it would cost every family in the United States the equivalent of $58 a year extra in income taxes.

If there are inadequacies in the present public and private programs for medical care for the aged, they can be rectified at much less cost to the taxpayer both in social security taxes and taxes paid to support the huge new additional bureaucracy that would be needed to administer the President's program.

Why kill flies with a shotgun when a fly swatter is handy?—*Indianapolis Star,* April 11, 1964.

Meeting The Doctor Bills

In apparent discouragement about the prospects for the administration's "medicare" proposal, the House Ways and Means Committee is said to be looking for some other plan to expand taxpayer-financed medical care for the aged.

The reported new project is to transform the Kerr-Mills program into a broad system of medical help for persons over 65, as well as for other groups who now receive some such benefits from public funds.

As it now operates, the Kerr-Mills program is rather specialized in its application. It is aimed at providing help with medical bills in the gap between persons on welfare rolls and those who are financially able to take care of such emergencies. Eligibility is based on financial means, but the rules are less restrictive than those for other welfare programs. Kerr-Mills programs are under state administration, with cost shared between state and Federal governments.

Said to be in the works is a proposal to expand it by liberalizing benefits until it would guarantee all persons over 65 against catastrophic medical bills.

The "medicare" proposal is not necessarily dead. It may be just playing possum. Under this plan, medical care for persons over 65 would be financed by an increase in the social security payroll tax. So far this plan has been stymied by opposition of persons concerned about the tax costs and the socialistic implications of such an all-embracing compulsory coverage.

The "compromise" scheme to expand and convert the Kerr-Mills plan apparently is aimed at a similar all-embracing coverage, with the bill presented to the taxpayers. The same objections apply.

There is no arguing the fact that many elderly persons have such limited resources that an expensive illness or injury would be financially catastrophic. But it does not follow that tax-paid medical care for all is necessary. It does not follow that a federal

Continued



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✳ precision
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program of any kind is required.

It is much more sensible to deal with such problems on a selective basis. Help should be available where it is genuinely needed, but it does not have to be spread around on a blanket basis. Selective help is best provided on a local or state basis. Privately supported help is usually better than tax-paid programs.—*Indianapolis Star,* May 17, 1964.

Tough Days For Drugs

If you are now taking a prescription medicine for some ailment, or if you have done so recently, the chances are at least 10 to one that your medicine will be affected by a Food and Drug Administration order requiring new approval for all drugs placed on the market between 1938 and the middle of 1953.

That covers 90% or more of all the drugs now in general medical use.

Manufacturers will be required to submit new information for each drug, providing proof of safety and effectiveness under new standards drawn up last year. In countless cases this may require new programs of testing for drugs in use for years.

Almost the whole range of medicines will be affected. The order will cover some of the sulphas and synthetic vitamins. It will apply to almost all the antibiotics, antihistamines, synthetic hormones, amino acids, antimalarials, antituberculars and radio-isotopes. It will cover the tranquilizers and the energizers. It will apply to the polio vaccine, the flu vaccines and other antiviral vaccines.

From that listing it is apparent that the FDA has taken on a prodigious task of reviewing. It has dumped a prodigious job of preparation on the drug manufacturers. And in this project the FDA has its hands on the whole array of modern medicines.

The FDA announcement pointed out it has power to order any drug taken off the market if the maker does not meet satisfactorily the new requirements. The regulation takes effect in October.

The best hope is that FDA officials will use the utmost care and common sense in applying this new regulation. Enforcement of the order with a broad and indiscriminate hand could bring chaos in the supply of prescription drugs.—*Indianapolis Star,* June 1, 1964.

A Job Ahead

The State Department of Mental Health employs nearly one-third of the state's work force.

In 1963, when the last total count was made, 6,742 Mental Health Department employees were treating and caring for 18,076 patients. The last session of the Indiana General Assembly approved a two-year budget of $91,427,811 to operate the program. This figures out to an estimated $5.45 per patient per day. Indiana need not be ashamed of this fact. That isn't high. But it is higher than the national average for 1963 which was pegged at $5.43.

Nor are the bulk of the employees badly paid. And they have finally been placed on a firm 40-hour work week, a long-needed step toward making the many mental hospital chores somewhat more palatable. These employees have the full advantages—such as they are—of the state's merit system and they are well protected in job security.

The major flaw in Indiana's mental health program has been in recruiting and keeping good physicians. Salaries are low indeed for the doctors who are responsible for treating the physical and mental ills of the state's helpless.

However unpleasant to acknowledge, mental health officials must face the fact that low incomes, isolated living, low morale, the near absence of a long-range and professionally exciting program won't attract top-level men for our institutions.

Everyone agrees that the state's helpless—and often hopeless—mental patients deserve the best custodial care possible and that every effort be made toward healing those who can be returned to society. We need competent physicians and psychiatrists to do that job. Salary increases are necessary if Indiana is to compete with enlightened neighboring states that are offering attractive financial rewards.

One doctor per 200 patients, Indiana's

present ratio, won't do.

A step in the right direction has been made in the granting of funds for training professional personnel in psychiatry, psychology, social work and activity therapy. These grants have been made—ranging from $10,000 to $20,000—by the Indiana Association for Mental Health, a volunteer group which raises its own money. And the General Assembly has set aside $200,000 for a two-year period to train these people in specialized fields.

Tom Karsell's series in *The Star* on mental health is designed to inform Indiana taxpayers where their money is going and what is being accomplished with its use. It is a tremendous outlay of our state wealth and every citizen should be interested.

We hope the next session of the legislature will make a searching examination into the whole structure of the Mental Health Department and perhaps formulate its own agonizing reappraisal.—*Indianapolis Star*, April 6, 1964. ◄

About Our Cover



What would we do without a calendar? Undoubtedly forget events like upcoming birthdays, important scientific meetings and imperative golf games!

Dates that you will NOT want to forget are those ringed on this month's cover — the days of the 115th annual ISMA convention.

This issue of *The Journal* brings you all of the "ingredients" of the annual meeting. With it you can plan the programs you wish to attend and also get a preview of the scientific and technical exhibits.

New additions to the regular convention offerings this year are an hour-and-a-half of continuous movies and the return of the instructional courses — the first time these courses have been offered since 1961.

Fireside conferences; general scientific and section meetings, all with excellent speakers; a special Political-Social-Economic program; the President's Luncheon; reception for 50-Year Club members; technical and scientific exhibits; a Gaslight Party in conjunction with the President's Reception — all have been planned so that you will learn, have fun and renew old acquaintances at the 1964 convention. Don't miss it! — J.F.S.



thrown for a loss...

Keeping flies out of pharmaceutical production areas is important, yet entrances must accommodate heavy traffic of people and materials. In fact, at Eli Lilly and Company, the entrances to certain production facilities where traffic is heaviest have no screens or doors. ☐ This makes it look easy for flies to get in. But let one try it and he is literally picked up by a fast-moving blast of air and thrown for a loss—back outside. This "curtain of air," moving down and out from the top of the open doorway, bars the entrance and keeps flies out . . . still another step demonstrating the care that goes into the finished product.

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Volvulus in the Pregnant and the Puerperal Patient

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INTESTINAL OBSTRUCTION associated with pregnancy is rarely reported. When obstruction is a problem during pregnancy, volvulus is one of the main causes. The incidence of intestinal obstruction in pregnancy has been found to vary from one in 3,600 pregnancies[4] to 14 to 34 per 1,000,000 deliveries.[2] Volvulus has been found by Guttmacher to comprise about 17% of these obstructions with adhesions being the most common cause.

In a recent review of the United States literature, 36 cases of volvulus associated with pregnancy were found up to 1963. Harer[3] reviewed the world literature up to 1958 finding 112 cases. Fifteen of these were in the United States. He added three which brought the total to 18. Isolated cases were reported in the United States literature up to 1962. Brannon[1] reviewed the literature at that time, and added four cases of his own. This brought the total in this country to 32. Single cases reported by Morton,[6] Siegler,[9] and Sargent,[8] were not included in Brannon's review. Todd,[10] in November, 1962, added one case, bringing the number of reported cases in this country to 36. Ostmann[7] reported a case of beginning volvulus around an adhesive band; however, this case is not included in this review. This paper documents the 37th case.

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Case Report

The patient was a 19-year-old colored female prima-gravida. Her expected date of confinement was March 5, 1962. She reported to the Marion County General Hospital on March 7, 1962 having had crampy abdominal pain for six hours prior to admission. She was taken to the obstetrical floor where approximately four hours later she was delivered of a living 6 lb., 10 oz. male. The delivery was accomplished under pudendal block. Twelve hours after delivery she complained of epigastric pain, nausea and had vomited several times. No distention was noted. No history of previous surgery had been obtained. Twenty-four hours post-partum, her pain was more intense, and she was distended. At that time, an emergency barium enema showed definite evidence of cecal volvulus (Figures 1,2,3). She was taken to surgery where a laparotomy was performed. The abdomen was opened through a right paramedian incision. Upon opening the peritoneum a greatly distended cecum was found lying in the epigastric area. The entire right colon and proximal one-third of the transverse colon was involved in a volvulus of 180° clockwise rotation. The torsion was released. No evidence of gangrene was present. An appendicocecostomy was done. The patient's postoperative course was unremarkable. Her cecostomy tube was removed in two



FIGURE 1
FLAT PLATE of the abdomen showing the distended cecum and appendix (arrow).



FIGURE 2
UPRIGHT FILM of the abdomen showing the air-fluid level in the cecum now located in the left upper quadrant.

weeks, and she has been seen in various clinics several times since, with no complaints referable to her gastrointestinal tract.

The etiology of volvulus associated with pregnancy has been considered by several observers. Whitaker,[11] feels that hypermobility of the right colon during pregnancy may be an underlying cause of cecal volvulus. Harer[3] thought that the rapid reduction in the size of the post-partum uterus gave rise to sudden changes in the position of the abdominal organs and resultant torsion of the bowel. In cases of cecal volvulus, there must have already existed an anatomic defect, in that volvulus of the cecum is impossible if the cecum is fixed in its normal position. In these cases, the cecum fails to become fixed during the embryologic rotation of the gut and remains free on a long mesentery. Other predisposing causes of volvulus, such as chronic constipation, diarrhea, trauma, obstructing lesions, enlarging pregnant uterus and generalized hyperperistalsis have been considered. However, it appears that adhesive bands are the most common cause of volvulus in pregnancy. These adhesions apparently act as an axis around which the bowel twists on itself. This was the case in three of the four cases reported by Brannon,[1] and in three of the four cases reported by Harer.[4] Harer[3] states that 25% of the cases of volvulus he reviewed had adhesive bands as their precipitating factor. It appears that this percentage is even higher when considering the 19 cases reviewed since 1958. In this group, nine cases or 47% were associated with adhesions. Thus, it appears that adhesions are not only the most common cause of intestinal obstruction in pregnancy, but also the most common cause of volvulus in pregnancy.

Harer[3] found before 1958, that 46% of the cases reported were of the sigmoid colon. Of the 19 cases reviewed since 1958, only one, five percent, involved the sigmoid colon. This case was reported by Malkasian,[5] and was adequately treated by placement of a colon tube. Most of the cases since 1958 have involved either the ileum, cecum, or both. The reason for this marked differ-



FIGURE 3
BARIUM ENEMA showing the point of torsion at the proximal transverse colon.

ence is not clear. The underlying etiological factors have not changed during the past ten years. Possibly, physicians are more acutely aware of the diagnosis at the present time.

The treatment of volvulus, except that occurring in the sigmoid, should be immediate laparotomy. Many authors have reported good results treating sigmoid volvulus by insertion of a colon tube. The case reported by Malkasian[5] was treated satisfactorily in this manner. The patient went on to have a normal delivery some two months later. However, if early satisfactory therapy cannot be obtained with the colon tube, then immediate laparotomy must be done.

In cases of volvulus involving bowel other than the sigmoid, immediate laparotomy is the treatment of choice. How the involved bowel is treated depends on the extent of injury and the surgeon's preference.

The indications for an associated Caesarian section are the same as those for any pregnant female who is critically ill. A near or full term uterus might make an operative bowel procedure very difficult, if not impossible. This would be the only additional indication for Caesarian section. It is best, of course, to repair the intestinal continuity, and allow the pregnancy to continue undisturbed.

Summary

A case of cecal volvulus in the immediate post-partum period is reported. This brings the total number of reported cases of volvulus associated with pregnancy in the United States literature to 37. A brief review of etiological factors and treatment is discussed.

Acknowledgment

The author wishes to thank Drs. Kingsley Lawrance, John D. MacDougall and Frederic W. Taylor for their assistance in preparing this paper.

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The Case of the Bemused Medic

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"DON'T DO AS I DO—do as I tell you!" How often has a patient heard this jesting injunction! It is a truism that the doctor treats himself has a fool for a doctor and a fool for a patient. Also, we surmise that, in the next world, one cannot sue oneself for malpractice no matter how generous the coverage of one's malpractice policy may be. And then, we have the impossible task of wondering whether suicide has been contemplated: either consciously or unconsciously. On the surface, it can be a very simple story; when probed, it can be an ever more perplexing, tangled tale.

Abe Apt came from a Pennsylvania village founded by a pioneer ancestor. That particular backwater was still run by the Apts like a personal fief; their word was still the law of the land—never mind all this democratic nonsense! The county seat had one bank: founded and managed by the Apts. The largest store—of course, was an Apt business. And so it went.

Abe was born with the proverbial silver spoon in his mouth. All the advantages of position, wealth, culture and education were at his disposal. His only brother was 14 months younger and, of course, had the same advantages. Just there—as I was to learn many decades later—lay the rub. The younger brother's spoon was not mere silver: it was pure, 22 karat gold.

When Abe was good, Al was ever so much better. It took the Apt name to get Abe on the high school football team—Al was the star quarterback. Abe had difficulty getting into the "right" college—Al had his pick. A desired medical school had to be strong-armed into accepting Abe—Al deliberately avoided medicine: he graduated at the head of his class from a famous law school. Abe just squeaked into a decent hospital—Al became the boy wonder judge while still in his twenties. Somehow, Abe never got his boards in surgery—Al is in line for top state and federal appointments. Without going on and on, you get the idea.

Curse of the Contretemps

I first met Abe when he was in his late thirties. He was on the surgical staff and I was on the medical roster. I had heard stories about the incredible bad luck that had dogged all his steps. There are some people who seem to have been born under an unlucky star.* Even if a skillful surgeon, his record of bad results barred promotions! Whatever he touched turned to

* Case of Misfortune's Stepchild, *JISMA* 54:5, May, 1961, pp. 636-641.

drab dross and ashes. At first glance, he seemed erect, handsome and vigorous BUT: what was that almost palpable something about him? Was it dejection? defeat? resignation? I remember being startled by his launching into a long apology about the sequence of disastrous complications that had plagued a patient on whom he had performed a very simple cholecystectomy. The internist (yours truly) had been called in; that is how we first met.

As I listened, I had a good view of the sloppy potbelly marring the former athletic physique. The head had a leonine mane of greying locks that would have looked better had they been combed. It *was* late morning but a good wash and a shave might have improved appearances. The keen, alert grey eyes were—somehow—lackluster. The aquiline nose lacked that raptorial snap! The lips sagged and drooped into creases, fading dejectedly into the angles of the jaw: a crumbling crag. An excellent suit was in need of pressing; the shirt was in its obvious second day. The knot in the expensive tie was awry, exposing the button it was supposed to cover. The gestures of the surgeon's hands were indecisive and apologetic. And—did those nails wear "mourning bands?" Such a first impression of a colleague is demoralizing: almost indecent. I dwell on it only because of what followed.

An Admonition Against Autodiagnosis

My contacts with Abe were always casual and always at the hospital. The stories anent his unhappy marriage—the scandal clinging to his adopted son. . . . Things like that were none of my business; I made professional allowances for his frailties; further I did not probe. One day, I bumped into him as I entered the doctors' locker room. Abe had taken a plastic pill-holder out of his pocket; he shook several varieties of pills into his palm; an odd one half-dozen were tossed down his gullet. Making conversation (a notorious weakness of mine), I said, "I'm sorry to see you indisposed; what gives?"

"Oh, I have a beginning arthritis; I'm in a lot of pain! I've been taking stuff for the last six months. My joints have been aching all winter; my sedimentation rate is away



up; my latex fixation test is positive."

"Have you been to see anyone?"

"Oh, no! The lab did the tests and the diagnosis is obvious!"

"And, pray; what *are* you taking?"

"Oh, butazolidine, one t.i.d.; two prednisones, ditto; also, a handful of aspirins whenever my fingers persist in stiffening. . . ."

Abe's nonchalance left me a bit aghast. "Don't you check your blood? Look for possible side-effects—in short, why not have a man you trust go over you?"

A slightly resentful shrug and an inane, sickly grimace told me that, as usual, I had talked too much. It was time for me to stop making conversation and go about my own business.

Less than a month later, I happened to be in the x-ray department: several of us were clustered to discuss a baffling diagnostic dilemma. In the viewbox on the opposite wall there were still several films of another case. The merest glance revealed the barium enema displaying an immense sigmoid diverticulum.

The roentgenologist had followed my straying gaze. "One of you chaps ought to talk to Abe Apt—Yeah, that is his gut! He had rectal bleeding yesterday and came in this morning for the enema. He's treating himself and I'm worried. That diverticulum has been with him a long time; it should not have started bleeding—just like that."

That very week-end, one of my residents called for surgical help. It was Abe Apt's turn; he came to take care of the acute surgical emergency. In the middle of the operation, Abe turned pale and all but fainted: the assistant had to take over and complete the task. Abe was placed on a stretcher and



taken to the V.I.P. room for massive, continuing rectal bleeding. A surgical colleague saw him within the hour but he was already in shock with all the unlovely sequelae beginning to manifest themselves. Blood, fluids, etc. were poured into him. The diagnosis seemed obvious: diverticulitis with massive hemorrhage. The treatment seemed just as obvious: resection of the offending bowel.

By nine o'clock that evening, Abe was back in his room; almost the entire lower one half of the colon had been excised; an end-to-end anastomosis was difficult but it was triumphantly accomplished. I saw him the next morning: he was lying in bed watching the bottle of blood hanging on the I.V. stand.

A Quiet Quietus

"That is the eighth pint since last night," was his opening gambit to me. "Doesn't look as if I'll make it, does it?" I was shocked to see the total resignation of the man; there was absolutely no fight left in him!

Abe Apt had had only the routine preoperative laboratory work. While the prothrombin time had been 23/13 and the hemoglobin only 10 gm., the surgeons had gone right ahead, confident in their ability to get at the source of the bleeding. They felt that generous blood replacement, vitamin K and restoration of electrolyte balance would solve their problems once the bleeding vessels were ligated.

The pathologist had examined the surgical specimen; he gave the attendings a rude shock. The resected bowel had oozed ominously from every possible surface but there was no *single* source to account for the continuing, tremendous exsanguination: there were no eroded veins or arteries: The huge diverticulum, by itself, did not explain the enormous hemorrhage. Belatedly, the internists had been called in to diagnose, advise and, possibly, even treat.

Of course, I had been privileged to know a good deal about the patient. Allergic drug reactions can be trifles and they can kill swiftly.* The least I could do was to obtain the broader battery of tests defining the basic hematological parameters. We did not have to go on and dig into the rarer Xmas factor, Rh, hexanoic acid titers and other exotic esoterica. The plain, ordinary thrombocyte count was down to a mere 20,000! Considering all the platelets that were being added from the blood being poured in —well, we could say that Abe Apt's own platelets had vanished!

But then—why was he bleeding so massively from the lower bowel only? Why were there no purpuric spots or ecchymoses elsewhere? And what was the *real* nature of Abe's joint pains? Did that self-made diagnosis of "rheumatoid arthritis" have any validity? Or did his reckless drug debauch merely aggravate something else altogether? As the medical cohorts deployed their skills, Abe's wife and his brother hovered near-by. That is how I managed to glean so much of the personal equation. Devoted nursing care was given around the clock. For some four days, there was a partial rally. The hemorrhage slowed to a trickle even if the flood of packed thrombocytes being poured into Abe's veins continued to be destroyed as fast as it entered the blood stream. Whatever the mechanism of the thrombocytolytic factors, they con-

* Case of Compounded Confusion, *JISMA* 57:4, April, 1964, pp. 336-340. We all know that aspirin is prone to produce painless gastrointestinal bleeding. Prolonged use of this most beneficent drug may be dangerous for this reason. This is also the reason for enteric coating of the pills. We will not discuss here *salicylism*, the mild form ranging all the way to the lethally toxic.

Butazolidin is a potent drug whose misuse can lead to serious results. Geigy, the manufacturer of the compound, is very specific in spelling out the possible dangers. They caution re agranulocytosis and leukemoid reactions; serum sickness may appear; tarry stools or frank *rectal bleeding* demand immediate withdrawal and careful, prompt medical care. And who is not aware of the fact the *steroids* will light up latent hemorrhagic tendencies?

Abe had been consuming all three in huge, uncontrolled amounts!

tinued their devastatingly destructive action.

On the fifth day, the abdomen began to distend: peritonitis was developing and ascites was forming. A needle was inserted into the ballooning belly: we were not surprised to withdraw very fluid, almost pure, blood. The internal sutures were sloughing and the whole operated field was leaking—and: *still* no thrombocytes! We had no answer as to the *why* of the hemorrhage coming only from the area supplied by the left colic artery. The patient continued to bear his ordeal with stoic resignation; he remained conscious until almost the very last. He died quietly just a week from the day he had collapsed in O.R.

A meticulous autopsy only confirmed the already ascertained fact of the pathology being confined to the left colic artery region. There was total vasodilation, venous and arterial; there was no single bleeding point: just the life draining oozing.*

Macroglobulinemia had to be considered in the differential diagnosis. *Medical Science*, March, 1964, carries an excellent article on that very topic. The pathologists called my attention to the elegant discussion and fine references given by the author, Dr. S. R. Hirsch. My friend, Jimmy, the eminent gastroenterological pundit, also made the most correct point that the very existence of the huge diverticulum underscored the existence of a "locus minoriae resistentiae" precisely in the area being discussed. He insists that the surgeons just had to operate; "what else was there to do?"

A Pharmaceutical Felo de Se?

Granting the actuality of all this, I'm left with the stubborn query of how does the TOTAL absence of thrombocytes fit in with a purely LOCAL manifestation demonstrated at surgery and at autopsy! It is true that we are accustomed to seeing systemic diseases display very peculiar (and characteristic) local signs. We can think of the "butterfly" of lupus erythematosus—or, the clubbing of pulmonary osteoarthropathy. A careful search of the literature available to me fails to mention a drug reaction producing the syndrome to which Abe Apt succumbed. Shall we call this new entity: "Apt's disease?"

Other reflections are a source of disquiet. I became acquainted with some personal aspects of the patient's life that I dare only hint at, here and there. Did Abe Apt *mean* to do away with himself in this ghoulish fashion? What *other* medicaments had he been sampling? Was *The Bemused Medic* indulging in malpractice or was there method in his madness?

Sometime I may meet him somewhere and get an answer—but I won't be in a position to tell all of you! As of now, I'll remember Abe Apt looking at that bottle of blood going in and saying, wryly, "Doesn't look as if I'll make it, does it?" ◄

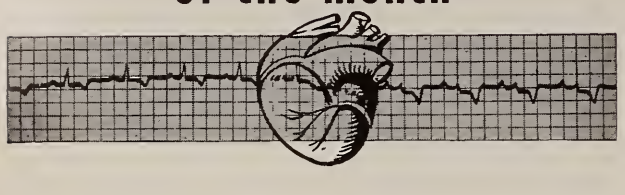
1270 Fifth Ave.,
New York, N.Y.

* There are hereditary variations in toxic reactions to drugs. See *Medical Tribune*, March 23, 1964, p. 3.

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E. J. Bowie, et al. in *Mayo Clinic Proceedings* for Feb., 1964 (Vol. 39, No. 2, pp. 144-151) have an excellent article on The Stability of Antihemophilic Globulin and Labile Factor in Human Blood. There are 17 references.

Electrocardiogram of the month



Presented as a regular feature of The JOURNAL, Electrocardiogram of the Month is a series of short talks on cardiovascular diagnosis and treatment, edited by the staff of the Krannert Heart Research Institute, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis.

Ventricular and A-V Nodal Tachycardia Due To Digitalis Complicating Atrial Fibrillation

CHARLES FISCH, M.D.
Indianapolis

THE VENTRICULAR RATE in rapid atrial fibrillation can usually be controlled with digitalis. There are occasional instances, however, in which despite the use of large doses of glycoside, one fails to slow the ventricular rate. Such is the case in instances of atrial fibrillation associated with thyrotoxicosis, anemia or when the arrhythmia is complicated by fever, embolization or infection. The tracing reproduced (Figure 1) is an example of failure of the rate to respond to high doses of digitalis. In fact the dose administered was sufficiently great to produce two manifestations of high degrees of digitalis toxicity, namely ventricular tachycardia and non-paroxysmal A-V nodal tachycardia.

The patient was a 64-year-old woman with combined rheumatic valvular disease, marked cardiac enlargement, atrial fibrillation and longstanding severe congestive heart failure. It was hoped by controlling the ventricular rate, the C-V situation might be improved.

Tracing taken on 4-22-64 shows atrial fibrillation with a ventricular response of about 150 per minute and occasional ventricular premature beats. In lead III there seems to be an extremely regular run of ventricular complexes which may or may not indicate A-V nodal tachycardia. Following additional digitalis, tracing on 4-27-64 shows a run of ventricular tachycardia as indicated by the QRS complexes which have the same appearance as the ventricular prematures on 4-22-64. At this point the digitalis was discontinued and on 4-28-64, the atrial fibrillation is accompanied by a regular ventricular response at a rate of 86 indicating the presence, in addition to atrial fibrillation, of an A-V nodal tachycardia. Thus a high degree of digitalis intoxication manifested by ventricular tachycardia and non-paroxysmal A-V nodal tachycardia was induced in a patient with atrial fibrillation without slowing of the ventricular rate.

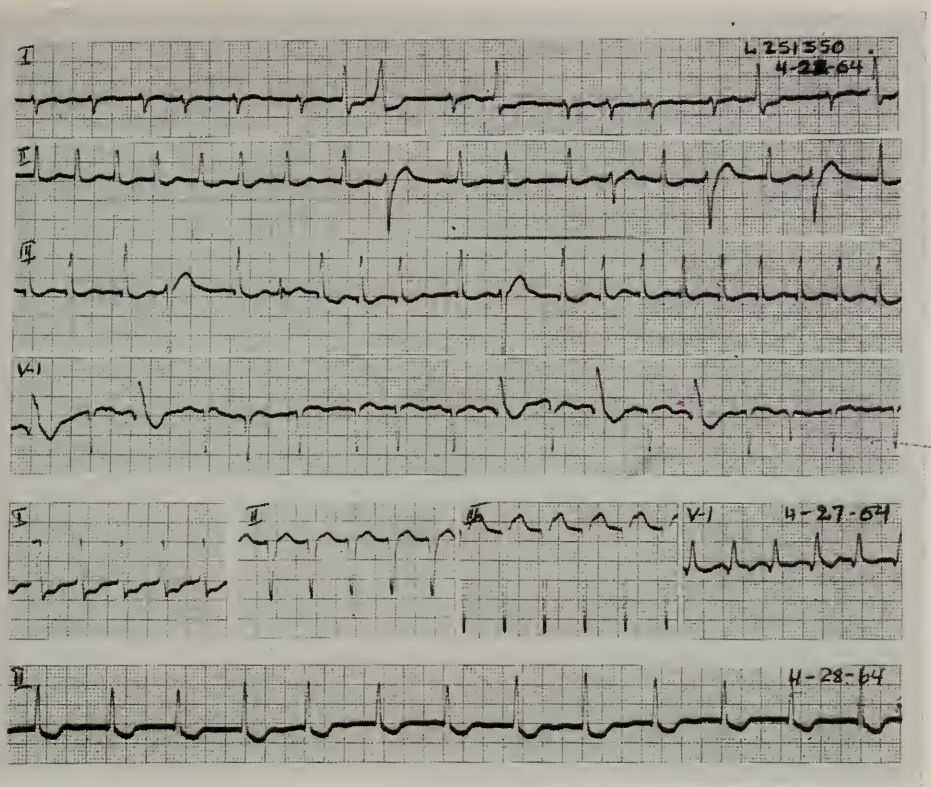


FIGURE 1

TRACING TAKEN on 4-22-64 shows atrial fibrillation with occasional ventricular premature beats. Ventricular tachycardia is evident on the 4-27-64 tracing and nonparoxysmal A-V nodal tachycardia on the tracing taken on 4-28-64.

X-RAY CONFERENCE

Presented as a regular feature of *The Journal*, X-ray Conference is a series of short talks on procedure and radiologic diagnosis, edited by Erich K. Lang, M.D.

Aneurysm of the Left Posterior Inferior Cerebellar Artery with Repeated Bleeding Episodes

E. CARL HANN, M.D. *
J. THEODORE LUROS, M.D. *
ERICH K. LANG, M.D. **
Indianapolis

A 31-YEAR-OLD white female was admitted to Methodist Hospital with diagnosis of subarachnoid hemorrhage.

Over the past 10 years, the patient had experienced repeated episodes of sudden onset of numbness of either the left face or arm, or both, associated with confusion and blurred vision. Headache, however, had not been a major problem. These episodes appeared to be more frequent preceding and following the menstrual cycle. Early this past summer, the patient experienced a syncopal attack and was unconscious for some 10 minutes. Severe left frontal headache and a stiff neck continued for the next four days. At this time, it was considered an attack of "summer flu." One day prior to admission to the hospital, a similar syncopal attack occurred. Her family physician noted marked nuchal rigidity and a lumbar puncture was characterized by grossly bloody spinal fluid. In retrospect, personality changes had been apparent for the past year; however no significance was attached to this finding.

Physical examination revealed a reasonably well oriented patient. No bruit was heard over head or eyes; carotid pulsations were equal. There was marked nuchal rigidity. Cranial nerves one through 12 appeared intact. A few nystagmoid movements on lateral gaze were noted; muscle strength was equal and full. There were no pathological reflexes in the upper extremities, but knee jerks were mildly hyperactive. An equivocal Babinski was present on the left side. Sensory modalities were intact throughout. There was no sensory suppression nor any visual field suppression; the visual field was normal to gross examination.

A vertebral arteriogram in the AP and lateral projection failed to demonstrate any significant abnormalities. However a catheter vertebral arteriogram in the oblique position demonstrated a huge compounded aneurysm arising from the left inferior posterior cerebellar artery (Figure 1). The inferior posterior cerebellar artery arises, in this case, from the vertebral artery rather than from the basilar artery and is best demonstrated in the oblique projection. A true lateral and AP Towne projection superimposed this area of high interest over dense bone of the foramen magnum. The aneurysm measured one and one-half centimeters in length and showed a long stalk.

Exploration of the posterior fossa revealed the base of the aneurysm. However, it was difficult to expose the neck without significant rotation of the medulla and midbrain. Hence, a double silver clip was applied to the left vertebral artery. The aneurysm collapsed immediately. The post-

* 1633 N. Capitol Ave.
** Radiologist, Methodist Hospital.



FIGURE 1
NOTE THE LARGE, pedunculated aneurysm arising from the left posterior inferior cerebellar artery close to the left vertebral artery. This oblique catheter injection best demonstrates the area.

operative course of the patient was unremarkable.

Discussion

Aneurysms of the basilar system will often elude angiographic detection. If arising from the basilar artery, they may be hidden behind the petrous bone and its air cells, but subtraction technic will often bring out this type of aneurysm. Aneurysms arising from the posterior inferior cerebellar artery, particularly, are often hidden behind the dense osseous structures of the foramen magnum.

Oblique projections and particularly catheter injection, with completely free motility of the neck during the injection phase, allows an accurate preoperative assessment of such aneurysms. It should be borne in mind that the needle arteriogram, while giving excellent detail, is often handicapped by the necessary immobility of the patient. Rotation of the skull will result in displacement of the needle from the lumen of

the vessel. The catheter vertebral arteriogram is extremely simple and, the left side is done with great ease.

From a femoral artery puncture, the guide wire will usually engage the left vertebral orifice during the first pass. A Snake-hook catheter is opportunely used to engage the right subclavian and vertebral artery. Retrograde injection of the vertebral via brachial puncture necessitates introduction of a large volume of contrast medium and may give rise to considerable discomfort to the patient. Moreover, it is difficult to accurately gauge the necessary amount that has to be injected to produce adequate flooding of the vertebral system. The Seldinger method via the femoral artery is practically free of serious complications. ◄

From *The Journal* 50 Years Ago

In the treatment [of malaria] quinin (sic) is given first place and is specific, if given in sufficient dosage and in a manner in which it is absorbed. Quinin tablets have been in my hands quite inert, as they are so insoluble that little therapeutic result is obtained. For several years I have been using a gelatin-coated pill made from a mass, made by adding to the ounce of quinin sulphate 1 dram capsicum, 1 dram hydrochloric and enough glycerin to make a pill mass. This mass can be made and rolled in rolls that can be cut and put in capsules. For several years I have had them made in two sizes, one containing 5 grains and one 2 grains quinin to each pill. The dosage should be regulated by the age of the patient and urgency of the case. In cases seen in office practice, I usually give 10 to 20 grains after supper each evening, for a variable length of time, then the same dose once or twice a week, as seems best for a period of a few months or a year, until the patient is free from the disease.

* * * *

Pains due to neuritis usually yield readily to aspirin and Cook's neuralgic pills.

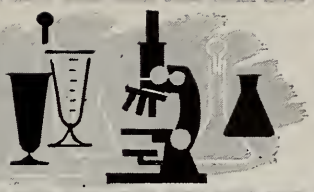
Cupping in the region of the inflamed nerve often gives immediate relief from pain.

Drinking hot water in large amounts gives great relief from the bilious vomiting so often present.

Iron, arsenic and strychnin (sic) to combat weakness and anemia should be given.

Where bilious vomiting is obstinate and profuse, a hyperdomic (sic) of morphin (sic) and atropin (sic), followed by a large dose "about 30 grains of quinin, as the patient comes under influence of narcotic," will usually give prompt relief George D. Marshall, M.D. "Prevalence and Manifestations of Malaria", *JISMA*, September, 1914.

Path-finder
PUBLISHED UNDER THE AUSPICES OF THE INDIANA ASSOCIATION OF PATHOLOGISTS



Pulmonary Function Tests (Part 1)

WEI-PING LOH, M.D.*
Gary

IN RECENT YEARS pulmonary function tests have gradually evolved from research procedures to clinical tests of real value and are generally available, even at small community hospitals.[1]

Pulmonary function tests are generally indicated when patients are known to have or are suspected of having chronic pulmonary disease. The general purpose of pulmonary function testing is to detect impairment and if present, to characterize it and estimate its severity. The specific purpose derives from the nature of the problem which the particular patient presents to his doctors or to interested third parties such as insurance companies, employers or compensation boards.

In a modern hospital there is as much need for a lung station as there is for a heart station.

What Pulmonary Function Tests Can Do

1. Provide an objective appraisal of pulmonary impairment when interpreted in relation to other findings in the patient.
2. Aid in distinguishing dyspnea of pulmonary disease from non-organic types of dyspnea such as psychoneurosis, neurocirculatory aesthenia, etc.
3. Aid in differentiating pulmonary dyspnea from dyspnea of cardiac origin.
4. Detect pulmonary disease in patients without physical signs or abnormalities demonstrable by x-ray.
5. Aid in differentiating primary from secondary types of polycythemia.
6. Aid in the evaluation of candidates for permanent forms of collapse therapy or surgical removal of lung tissue, both so far as immediate risk and ultimate useful existence are concerned.
7. Evaluate objectively the effect of therapeutic measures, both medical and surgical, on pulmonary function.
8. Follow objectively certain aspects of the course of pulmonary disease.
9. Indicate the specific function of the lung that has been impaired by disease and give the physician a clearer concept of the disease process in each patient.
10. Be useful in pre-employment evaluation.
11. Provide medical-legal evaluation of impaired pulmonary function.
12. Evaluate serially possible effects on pulmonary function from occupational exposure to possibly hazardous dust or fumes.

What Pulmonary Function Tests Cannot Do

Pulmonary function tests either singly or in combination cannot provide:

1. Etiological or anatomical diagnoses.
2. Precise anatomical localization of a physiological defect.
3. Evidence of pulmonary disease until there is sufficient alteration of physiological processes.
4. A substitute for careful history, physical examination and radiological,

* Chief Pathologist, Methodist Hospital of Gary; Assistant Professor of Pathology, Chicago Medical School.

bacteriological and pathological studies.

A cooperating and understanding patient is essential for accuracy of all spirometric measurements. Therefore, spirometry will be of no value in the mentally retarded or the individual who is malingering.

The use of pulmonary function tests in children with a lower age limit for cooperation and understanding of six to eight years, is limited to the determination of the vital capacity and peak flow rates.[2]

(To be continued next month).

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2. Cook, C. D.: Assessment of ventilatory status in pediatric patients, *International Anesthesiology Clinics*, Little Brown & Co., Boston, 1962.

1964 Instructional Courses

Have you filled out *your* application for the 1964 Instructional Courses to be given on Wednesday, October 14?

The list of courses offered and the application blank appeared on pages 920 and 921 of the August *Journal.*

If you have mislaid your August issue, *The Journal* office will be glad to supply you with the details.

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

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Mental Health Congress

THE SECOND NATIONAL CONGRESS on Mental Illness and Health will be conducted by the Council on Mental Health of the AMA in Chicago November 5 to 7.

The first congress was held in October, 1962. Much was accomplished then in outlining the problem and in planning the preliminary attack upon what the AMA said was "the nation's most pressing and complex health problem."

The program in 1962 was based on two tenets—the importance of psychiatric principles to all physicians; and the need for comprehensive mental health services and facilities within the community. Both these points were included in the late President Kennedy's special message to Congress, which since has passed into law provisions for construction of community mental health centers.

Interest at state and community levels has risen as a result of AMA activity in this field. Local endeavors have produced advances and have also developed and uncovered new problems. Since most of these new considerations are concerned with community activities, and since mental health needs vary with the size of the community, the congress will conduct simultaneous sessions in all groups and subdivisions for major metropolitan, smaller metropolitan and rural needs.

Practically the entire conference will be conducted on the workshop principle, with a minimum of lectures. Its purpose will be to orient physicians, particularly those in private practice, and interested community leaders toward activating and participating in effective mental health programs at the community level.

Write the Palmer House for room reservations. Write the AMA Council on Mental Health, 535 N. Dearborn St., Chicago, for more detailed information.

Community Health Week

COMMUNITY HEALTH WEEK will be observed October 18 to 24, under the sponsorship of the American Medical Association and its component county medical societies all over the nation.

In acknowledging improvements in health due to advances in medicine, the medical profession will be able to promote the interest of the public in taking full advantage of all such advances for even

better health.

It has often been said that we do not need any more medical discoveries; all we need to do is influence everyone to take advantage of those things already discovered and not presently used to the maximum extent. Community Health Week will be an ideal time to acquaint the general public with the many health giving procedures which are too seldom used.

Newspapers, radio, television and other avenues of public information will be utilized to further the cause of periodic health checks, proper immunizations, regular exercise and use of community health facilities, as well as safety campaigns for drivers, drug and poison safety in the home and the new emergency medical identification tag.

Community Health Week will also afford an opportunity to generate the interest of young people in careers in the health field. Physicians, nurses, dentists, technicians and research workers all have a stake in the publicity measures which will be promoted from October 18 to 24.

Guest Editorial

Killing the Goose

IN MANY of the major countries of the world, including the United States, an attack is being mounted on the patent system, which has been the source of so much of the improvement in human welfare. For the moment, the attack is concentrated on patents in the pharmaceutical field, but the same arguments could easily be applied to the whole principle of patent protection.

In the words of the United States Constitution, the purpose of patent protection is to "promote the progress of science and useful arts" and the method is to secure inventors, for a limited period, "the exclusive rights" to their discoveries. Compulsory licensing, as now contemplated, is hardly consistent with the concept of a patent as granting "exclusive rights."

The basic argument advanced to support such proposals is a humanitarian one—people should not be compelled to pay more for lifesaving drugs than they would pay in the absence of patent protection. This sounds appealing, but it overlooks the question of whether these drugs would have been developed at all without the promise of patent protection. Inexpensive drugs may save more lives than expensive ones, but nonexistent drugs will save no lives at all.

Patent rights are property rights, in just as real a sense as the ownership of a home or automobile is a property right.

Research in the pharmaceutical field is both costly and risky. Huge sums must be spent, with no guarantee that the results will be successful or that it will not quickly be superseded by something even better. Obviously, no firm will undertake such a program if it will have to share its successful discoveries with other firms who bore no part of the expense or the risk.—George Hagedorn, Director of Research for the National Association of Manufacturers. Reprinted from *Medicine at Work*, July, 1964. The article originally appeared in the *NAM News*.

Editorial Notes . . .

A blood test for PKU is described in the April 20 issue of the *JAMA*. It has the advantage of determining the presence or absence of phenylketonuria soon after birth, thus allowing early diagnosis and treatment. The urine test for PKU usually does not become positive for four to six weeks after birth. The blood test may be done while the baby is still in the hospital—therefore a greater proportion of babies may be tested.

Air travelers may enter the United States in the infectious but nonsymptomatic phase of early smallpox and unwittingly endanger others. Civilian employees of the Army and the Public Health Service who are in frequent contact with such travelers have been advised to be re-vaccinated every three years. Approximately 90,000 persons enter the country each day and of this number, about 1,000 arrive from countries where

smallpox is present.

Students at Indiana University School of Medicine won the most honors in the SAMA-Eaton Medical Art Salon recently at the annual SAMA convention. They acquired a second place in medical photography, a third place in illustration and three honorable mention awards.

Professor Ruddell Reed of Purdue has devised a mathematical system of inventory control which may be applicable to hospitals. The system is adaptable for use by a computer and tends to eliminate errors of human judgment. A two-year test run in the University of Florida Hospital at Gainesville on nine major items resulted in a lower level of inventory, without any item being out of supply at any time during the two years. Further tests are planned.

The socialist-communist theme "from each according to his ability" and "to each according to his need" is neatly slaughtered by Thomas J. Shelly, a teacher at Yonkers High School now associated with the Foundation for Economic Education. Whenever students express admiration for communism, Mr. Shelly always offers to juggle their grades, taking from the high marks to add to the low marks, thus producing an average grade just above passing. When the students realize that this system removes all incentive for learning, they are quickly disillusioned and begin to believe in private enterprise.

Indiana led the country's largest industrial states in per capita capital expenditures for new manufacturing plants and equipment during the 10-year period of 1953-62. We ranked eighth among the states on the basis of dollar volume with a total of $4,755,580,000. However on the basis of population, Indiana was first with $1,061.99 per person.

Most Indiana communities are so short of hospital beds that it is almost impossible to imagine building too many hospitals, or for that matter building them in the wrong part of town. However, even now, community planning for hospital building has one very important reminder for everyone. Every hospital should not be equipped for open-heart surgery, cardiac catheterization, electro-encephalography, or for use of artificial kidneys. Expensive equipment which requires a highly trained staff should be installed only in locations where it will be used most of the time. Occasional use will otherwise inflate the cost per patient and allow the staff to lose its skill.

The Aetna Life Insurance Company has been issuing health insurance on a trial basis to people who were at one time considered uninsurable due to chronic disease. The insurees have collected nearly one million dollars in the pioneer program. Premium rates are based on type and severity of physical impairment. The plan applies to both hospitalization and income-replacement insurance. The plan is so successful the company has recently raised income replacement limits from $200 a month to $500. Accidental death benefits have also been raised—from $5,000 to as high as $25,000.

Since 1939, almost 23,000 refugee doctors have been integrated into the medical profession of the United States. Originally the counselling and placement of refugee physicians was handled by the National Committee for Resettlement of Foreign Physicians. Now the work is done by the American Council for Emigres in the Professions (ACEP). Dr. Robert Boggs is the present director and served as chairman of the original committee. ACEP is concerned not only with physicians but looks after engineers, scientists, teachers, lawyers, architects and artists.

Of the 365 basic new drugs introduced in this country since 1941, more than 90% have come from the pharmaceutical industry, about nine percent from universities and state institutions and less than one percent from the federal government. One of the most valuable federal programs under way now is the screening of chemicals in the search for cancer control substances. ◄

President's Page

Our State Convention this year promises to be an excellent meeting.

The scientific section will include papers by distinguished leaders in medicine.

The special economic and political affairs portion of the program on Thursday morning will be outstanding. We have the promise of the two Indiana Senatorial candidates to present their ideas on issues of the day. Following them will be Dr. E. B. Howard of the AMA relating medicine and the political scene. I-HOPE will be represented by its chairman, Dr. William G. Bannon. AMPAC will be represented by Mr. Joe Miller, Executive Director.



I am extremely hopeful that Mr. William Miller, Vice-Presidential candidate, will be present to speak at your president's noon luncheon. The House of Delegates will have a full agenda covering all of the phases of association business.

This is a superior program and promises to be a convention long to be remembered. I will certainly be looking forward to your attendence and participation. Let us make this the largest and best convention ever.

Donald E. Hood



The Doctor's Visit, Jan Steen 1626-1679, Mauritshuis, The Hague

In Diverticulosis and Diverticulitis...

METAMUCIL® brand of psyllium hydrophilic mucilloid

"Diverticulosis ... a low-roughage diet is advisable.... Constipation is avoided, preferably by the daily use of Metamucil.

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Usual Adult Dosage: One rounded teaspoonful of Metamucil (or one packet of Instant Mix Metamucil) in a glass of cool liquid one to three times daily.

Metamucil is available as Metamucil powder in containers of 4, 8 and 16 ounces and as flavored Instant Mix Metamucil in cartons containing 16 and 30 single-dose packets.

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SEARLE

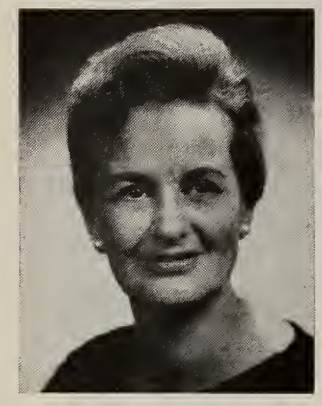
Research in the Service of Medicine

The Woman's Auxiliary

REPORTS TO ISMA

At the AMA Auxiliary Convention in June, emphasis was placed on the importance of Auxiliary members letting their voices be heard within other organizations and helping with projects, particularly in the field of medicine and public health. In this way others will know that as an Auxiliary and as individuals we are genuinely interested in them, in their interests and in Community Service. We can provide materials for sound health programs.

The new *Bulletin,* our national publication, is now being sent to our more than 85,000 members so that each can be informed about what is being done within the Auxiliary. With better understanding through *The Bulletin* we can go to other groups and say, "Now we can help."



Representatives from 75 voluntary women's organizations were guests at a luncheon during our national convention. Our president, Mrs. C. Rodney Stoltz, said to those present, "There is very little time for the trivial and the irrelevant today. We stand ready to help you in those areas of the health field. . . . The woman's viewpoint might make the difference between success and failure. . . . We want to keep the dream to keep America what we have always known it to be."

Ever Curtis, M.D., of the AMA Speakers Bureau, suggested that we carry a little notebook with facts and figures and bring it out over the bridge table or at cocktail parties to convince others of what has been happening with socialistic trends in America. She told how complete socialism comes, piece by piece, bit by bit, little by little, because too many believe in what "sounds good" at the time, but that we must convince people of the "eventual good." She said it takes real courage to stand before a small group and say, "This is not right," and encouraged us to work as individuals within organizations, particularly church groups.

Dr. Edward R. Annis told of the medical advantages the people of our country have as compared with those who live in socialistic countries. He said that as good citizens we must "tell the story" and thus contribute to the preservation of our free society.

Bea Shields

115th
Annual Convention

INDIANA STATE MEDICAL ASSOCIATION

October 12, 13, 14, and 15, 1964
All Events on Eastern Standard Time
Murat Temple, Indianapolis, Indiana

Complete Program and Annual Reports on Following Pages

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Official Call to the House of Delegates

The next annual session of the Indiana State Medical Association will be held at the Murat Temple, Indianapolis, Indiana, October 12, 13, 14 and 15, 1964.

The House of Delegates will be constituted as follows: Marion County, 20 delegates; Lake County, nine delegates; Allen County, six delegates; St. Joseph and Vanderburgh county societies, each five delegates; Delaware-Blackford, three delegates; Bartholomew-Brown, Daviess-Martin, Dearborn-Ohio, Elkhart, Fayette-Franklin, Fountain-Warren, Harrison-Crawford, Jackson-Jennings, Jefferson-Switzerland, LaPorte, Madison, Owen-Monroe, Parke-Vermillion, Tippecanoe, Vigo and Wayne-Union county societies, each two delegates; the other 58 county societies, each one delegate; 13 councilors and the ex-presidents, namely George R. Daniels, F. S. Crockett, Herman M. Baker, Karl R. Ruddell, M. A. Austin, Augustus P. Hauss, Paul D. Crimm, W. Harry Howard, Walter U. Kennedy, Elton R. Clarke, M. C. Topping, Kenneth L. Olson, Earl W. Mericle, Guy A. Owsley and Maurice E. Glock, and ex-officio, the president, president-elect, executive secretary and the treasurer of the association, and the delegates to the American Medical Association, all without power to vote, except in the case of a tie vote, when the president shall cast the deciding vote.

All delegates have been certified by their county medical societies. No delegate will be seated unless wearing the official badge.

The House of Delegates will convene promptly at 7:00 p.m. Monday, October 12, 1964, in the Ballroom, Columbia Club, and again at 2:00 p.m. Thursday, October 15, 1964 in the Candidates Room, Murat Temple.

The order of business will be as follows:

1. Call to order by the president.
2. Invocation.
3. Roll call and seating of qualified delegates.
4. Tribute to members of House who have died since the 1963 session.
5. Reading of the minutes of previous meetings.
6. Introduction of guests.
7. Appointment of Reference Committees and assignment of meeting rooms.
8. Unfinished business.
 a. Amendments to Constitution.
9. Address of president-elect.
10. Report of President of the Woman's Auxiliary.
11. Report of Indiana Chapter Student A.M.A.
12. Report by president of Blue Shield.
13. Report of executive secretary.
14. Report of treasurer.
15. Report of the chairman of the Council.
16. Reports of councilors.
17. Report of *Journal* Editor.
18. AMA Delegates' report.
19. Report of State Board of Medical Registration and Examination.
20. Reports of committees and commissions:

 COMMITTEES:

 (1) Executive
 (2) Grievance
 (3) Student Loan
 (4) Medical-Legal Review
 (5) Building Committee.

 COMMISSIONS:

 (1) Convention Arrangements
 (2) Constitution and Bylaws
 (3) Legislation
 (4) Public Information
 (5) Governmental Medical Services
 (6) Public Health
 (7) Voluntary Health Agencies
 (8) Inter-Professional Relations
 (9) Medical Economics and Insurance
 (10) Medical Education and Licensure
 (11) Special Activities
 (12) Aging

18. New Business.

 (1) Resolutions from the floor.

The election of officers will be the first order of business at the second meeting of the House of Delegates. In addition to the regular officers, the terms of the following officers expire December 31, 1964, and their successors must be elected at the session: delegates to the American Medical Association to succeed Harold C. Ochsner, Indianapolis, E. S. Jones, Hammond and Francis L. Land, Fort Wayne.

Delegates from the Third, Sixth, Ninth and Twelfth districts are reminded that the terms of their councilors will expire October 15, 1964, and the new councilors should be elected to succeed the following:

Third District—John M. Paris, New Albany
Sixth District—William R. Tindall, Shelbyville
Ninth District—K. O. Neumann, Lafayette
Twelfth District—Milton F. Popp, Fort Wayne

Some of these elections already may have been held, but they should be reported to the House of Delegates at this session for confirmation.

JAMES A. WAGGENER, *Executive Secretary*

HOUSE OF DELEGATES

Indiana State Medical Association

Indianapolis—October 12, 13, 14, and 15, 1964

County and Delegates	Alternates
ADAMS	
C. William Freeby, Decatur	
ALLEN	
John R. Ball, Fort Wayne	Richard G. Fullam, Fort Wayne
Richard G. Juergens, Fort Wayne	Robert L. Hillery, Fort Wayne
John E. Krueger, Fort Wayne	Walter T. Jurgensen, Fort Wayne
Eugene F. Senseny, Fort Wayne	Gerald R. Nolan, Fort Wayne
William A. Kleifgen, Fort Wayne	Edwin W. Stumpf, New Haven
W. Lloyd Bridges, Fort Wayne	John S. Farquhar, Fort Wayne
BARTHOLOMEW-BROWN	
Lindley L. Gammell, Columbus	Lowell Beggs, Columbus
Robert Seibel, Nashville	Kenneth Schneider, Columbus
BENTON	
D. L. McKinney, Otterbein	Verne L. Turley, Fowler
BOONE	
Clarence G. Kern, Lebanon	Don W. Boyer, Lebanon
CARROLL	
T. Neal Petry, Delphi	George W. Wagoner, Delphi
CASS	
Earl W. Bailey, Logansport	Donald Winter, Logansport
CLARK	
Joseph Carr, Henryville	Claude Meyer, Sellersburg
CLAY	
Rahim Farid, Brazil	
CLINTON	
Robert A. Hedgcock, Frankfort	
DAVIESS-MARTIN	
Robert H. Rang, Washington	C. Philip Fox, Washington
E. B. Lett, Loogootee	R. E. Chattin, Loogootee
DEARBORN-OHIO	
Leslie M. Baker, Aurora	Ivan Lindgren, Lawrenceburg
Gordon S. Fessler, Rising Sun	
DECATUR	
William Shaffer, Greensburg	
DE KALB	
John Hines, Auburn	
DELAWARE-BLACKFORD	
Thomas M. Brown, Muncie	Philip Ball, Muncie
Glynn A. Rivers, Muncie	Clyde Botkin, Muncie
Dean Jackson, Hartford City	Richard Ingram, Montpelier
DUBOIS	
John Barrow, Dale	Edward Ploetner, Jasper
ELKHART	
John P. Turner, Goshen	Thomas J. Quilty, Goshen
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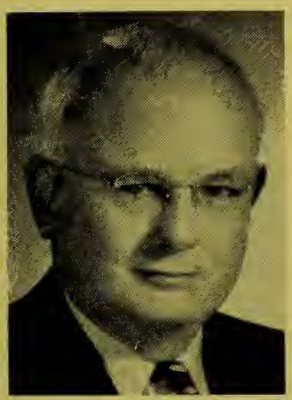
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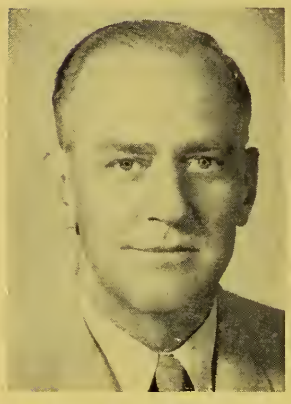
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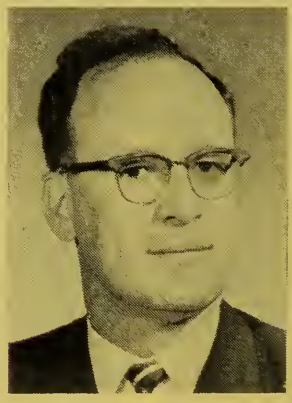
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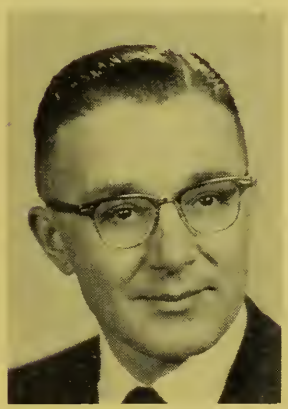
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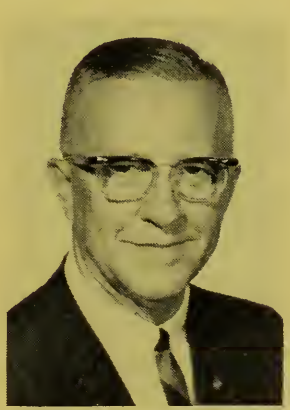


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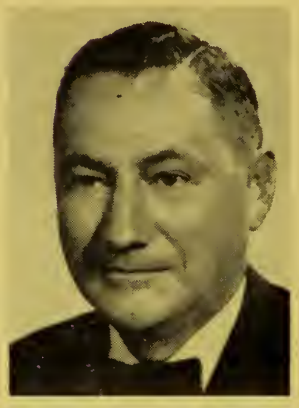
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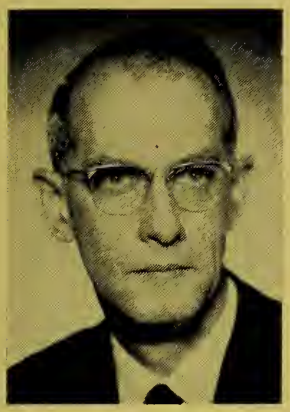
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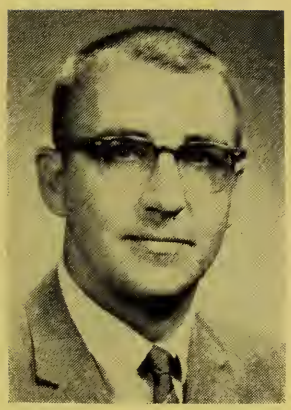
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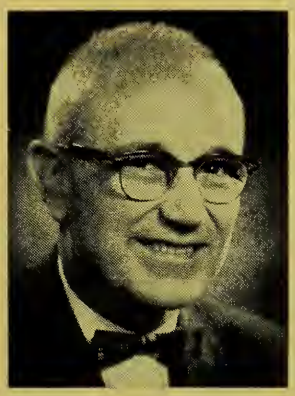
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Schedule of Events

115th Annual Convention

Indiana State Medical Association

Murat Temple, Indianapolis, Indiana

October 12, 13, 14, 15, 1964

(All Events on Eastern Standard Time)

(The scientific program of the 115th annual convention of the Indiana State Medical Association is acceptable for 10½ accredited hours by the American Academy of General Practice.)

Monday, October 12, 1964

12:00 noon Executive Committee meeting, Fairbanks Room, fourth floor, Columbia Club

3:00 p.m. Council meeting, Parlors B and C, fourth floor, Columbia Club

7:00 p.m. Meeting of House of Delegates, Ballroom, Columbia Club. (Not a dinner meeting.)

Tuesday Morning, October 13, 1964

7:30 a.m. Breakfast meeting of the Council, Harrison Room, Columbia Club

8:30 a.m. Registration starts, lounge room, Murat Temple

8:30 a.m. Opening of technical and scientific exhibits, lounge room, Murat Temple

9:00 a.m. Reference Committee meetings, basement dining room, Murat Temple

11:00 a.m. to
1:00 p.m. Time allowed to view technical and scientific exhibits

Tuesday Noon, October 13, 1964

12:00 noon Luncheon meeting of past presidents of the Indiana State Medical Association, Ladies Parlors (small room), Athenaeum

12:00 noon Editorial Board luncheon meeting, Directors' Room, Athenaeum

12:00 noon Luncheon and election of Section Officers for 1965, SECTION ON OBSTETRICS AND GYNECOLOGY, Ladies Parlors (large room), Athenaeum

12:00 noon Joint luncheon meeting of SECTION ON RADIOLOGY and Indiana Roentgen Society, Blue Room, Athenaeum

"Pediatric Urology"
JOHN P. DORST, M.D., Cincinnati, Ohio

Election of Section officers for 1965

12:00 noon Indiana Association of Pathologists luncheon meeting, Fraternity Room, Athenaeum



JAMES S. FITZPATRICK, M.D.
Portland
General surgery; M.D. from Indiana University School of Medicine, 1944.

Tuesday Afternoon, October 13, 1964

SECTION MEETINGS

1:00 p.m. SECTION ON SURGERY, Foyer, Candidates Room, Murat Temple

1:00 to 3:00 p.m. Symposium on *"Vascular Surgery"*

Moderator: JAMES S. FITZPATRICK, M.D., Portland

"Surgical Management of Acute Arterial and Venous Trauma
JOHN A. WALDHAUSEN, M.D., Indianapolis

"Current Status of the Surgical Treatment of Aortic Valve Disease" Film of operation to be shown.
HARRIS B SHUMACKER, Jr., M.D., Indianapolis

"Diagnosis and Management of Acute Thrombophlebitis, Including Indications for Vena Caval Ligation"
ISIDORE MANDELBAUM, M.D., Indianapolis

"The Use of Cardiac Pacemakers for Complete Heart Block" Film of operation to be shown.
HAROLD KING, M.D., Indianapolis

2:00 p.m. Discussion and questions from the audience

Election of Section officers for 1965

SPEAKERS



JOHN A. WALDHAUSEN, M.D.
Indianapolis
Assistant Professor of Surgery, Indiana University School of Medicine; Specialist in general and thoracic surgery; M.D. from St. Louis University School of Medicine, 1950.



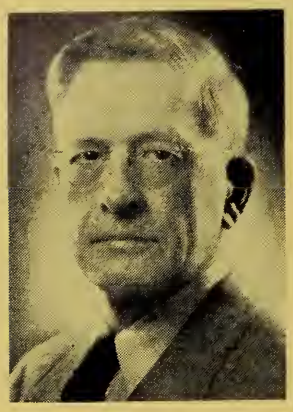
HARRIS B SHUMACKER, JR., M.D.
Indianapolis
Professor and Chairman, Department of Surgery, Indiana University School of Medicine; Consultant in surgery, Veterans Administration and Marion County General Hospitals; M.D. from Johns Hopkins University, 1932.



ISIDORE MANDELBAUM, M.D.
Indianapolis
Assistant Professor of Surgery, Indiana University School of Medicine; Specialist in general and thoracic surgery; M.D. from State University of New York Medical Center, 1952.

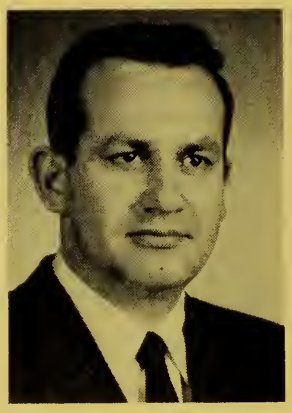


HAROLD KING, M.D.
Indianapolis
Professor of Surgery, Indiana University School of Medicine; Specialist in general and thoracic surgery; Consultant in surgery, Veterans Administration and Marion County General Hospitals; M.D. from Yale University School of Medicine, 1946.



JAMES O. RITCHEY, M.D.
Indianapolis

Professor Emeritus, I. U. School of Medicine; Specialist in internal medicine; M.D. from Indiana University, 1918.



JAMES C. HUNT, M.D.
Rochester, Minn.

Assistant Professor of Medicine, Mayo Foundation Graduate School, University of Minnesota; Consultant, Dept. of Medicine; Head of Section of Nephrology; M.D. from Bowman Gray School of Medicine, 1953.



B. L. MARTZ, M.D.
Indianapolis

Associate Professor of Medicine, I.U. School of Medicine; Director, Lilly Laboratory for Clinical Research, Marion County General Hospital; Past President, Indiana Heart Assn.; M.D. from Indiana University, 1945.



EVAN W. THOMAS, M.D.
Philadelphia, Pa.

Consultant to the United States Public Health Service; Specialist in venereal diseases; M.D. from the New York University of Medicine, 1933.



ZIGMOND M. LEBENSOHN, M.D.
Washington, D.C.

Professor of Clinical Psychiatry, Georgetown University School of Medicine; Chief of Dept. of Psychiatry, Sibley Memorial Hospital, Washington; M.D. from Northwestern University, 1934.

Tuesday Afternoon, October 13, 1964

SECTION MEETINGS

1:00 to
3:00 p.m. SECTION ON INTERNAL MEDICINE, Egyptian Room, Murat Temple

"Diagnosis and Treatment of Hypertension"

Moderator: JAMES O. RITCHEY, M.D., Indianapolis

Panel: JAMES C. HUNT, M.D., Rochester, Minnesota

BILL L. MARTZ, M.D., Indianapolis

Election of Section officers for 1965

1:00 p.m. SECTION ON PUBLIC HEALTH AND PREVENTIVE MEDICINE, Candidates Room, Murat Temple

"Venereal Disease, the Mounting Threat"
EVAN W. THOMAS, M.D., Chicago

"Eradication of Tuberculosis in Indiana"
ANDREW C. OFFUTT, M.D., Indianapolis

"Plastic Surgery for Birth Defects"
JAMES E. BENNETT, M.D., Indianapolis

Election of Section officers for 1965

1:00 p.m. SECTION ON NERVOUS AND MENTAL DISEASES, Basement Foyer, Murat Temple

"American Psychiatry and the General Hospital"
ZIGMOND M. LEBENSOHN, M.D., Washington, D. C.

Election of Section officers for 1965

Tuesday Afternoon, October 13, 1964

SECTION MEETINGS

2:00 p.m. SECTION ON OBSTETRICS AND GYNECOLOGY, Ladies Parlors (large room), Athenaeum

2:00 to
3:00 p.m. *"Office Gynecology"*
NORMAN F. MILLER, M.D, Ann Arbor, Michigan

3:00 to
3:15 p.m *"Breech Delivery Mortality"*
JOSEPH F. THOMPSON, M.D., Indianapolis

3:15 to
3:30 p.m. *"Demonstration of Method of Breech Delivery"*
JOHN F. SPAHR, Jr., M.D., Indianapolis

3:30 to
4:00 p.m. Question and answer period

Moderator: WILLIAM A. KARSELL, M.D., Indianapolis

Participants:
NORMAN F. MILLER, M.D.
JOSEPH F. THOMPSON, M.D.
JOHN F. SPAHR, Jr., M.D.

4:00 to
5:00 p.m. Time allowed to view technical and scientific exhibits, lounge room, Murat Temple

Tuesday Evening, October 13, 1964

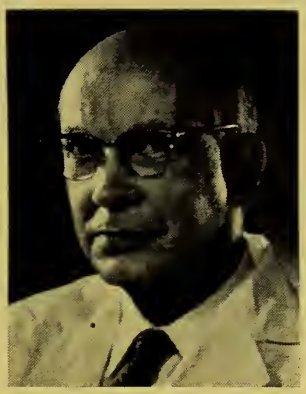
6:00 p.m. Reception and annual dinner meeting for women physicians, Parlors D and E, fifth floor, Indianapolis Athletic Club

6:00 p.m. Indiana chapter of the American College of Chest Physicians Annual Dinner and Business Meeting, Third Floor, Columbia Club.

"Atypical Pulmonary Infection"
KARL PFUETZE, M.D., Hinsdale, Ill.

"Surgical Treatment of Coronary Artery Disease"
F. MASON SONES, JR., M.D., Cleveland, Ohio

SPEAKERS



NORMAN F. MILLER, M.D.
Ann Arbor, Mich.

Professor Emeritus, Michigan Medical School; Head of the Department of Obstetrics and Gynecology, Michigan Medical School; M.D. from Michigan Medical School, 1920.



JOHN F. SPAHR, JR., M.D.
Indianapolis

Associate in Obstetrics, Indiana University School of Medicine; Specialist in obstetrics and gynecology; Consultant, Marion County General Hospital; M.D. from I. U. School of Medicine, 1940.



WILLIAM A. KARSELL, M.D.
Indianapolis

Clinical Assistant, Department of Obstetrics and Gynecology, I. U. School of Medicine; Specialist in obstetrics and gynecology; M.D. from I. U. School of Medicine, 1942.

Fireside Conferences

on

CARDIO-RESPIRATORY DISEASES

Tuesday, October 13, 1964, 8:00 P.M.

Ballroom, Columbia Club

This is an annual feature of the convention sponsored by the Indiana State Medical Association and the Indiana chapter of the American College of Chest Physicians for all physicians. The conferences are informal and unrehearsed, providing an opportunity for free discussion of many subjects of interest to general practitioners and specialists alike. A panel of experts will be seated at each of ten tables, and physicians are encouraged to ask questions, express their own ideas, and comment on the various problems under discussion. They may move from one table to another if and when they wish. (Complimentary refreshments will be served during the evening.)

Honored Guest Participants

KARL PFUETZE, M.D., General Administrator, Suburban Cook County Tuberculosis Sanatorium District, Hinsdale, Illinois; Clinical Professor of Medicine, University of Chicago, College of Medicine, Chicago, Illinois.

F. MASON SONES, JR., M.D., Head of Department of Pediatric Cardiology, Cardiology Laboratory, Cleveland Clinic Foundation, Cleveland, Ohio.

1. *Cerebrovascular Accidents*
 Moderator: KENNETH R. WOOLLING, M.D., Indianapolis
 J. THEODORE LUROS, M.D., Indianapolis
 DWIGHT SCHUSTER, M.D., Indianapolis
 FELIX MILLAN, M.D., Indianapolis

2. *Anesthetic and Postoperative Cardio-pulmonary Problems*
 Moderator: KINGSLEY L. LAWRANCE, M.D., Indianapolis
 RICHARD W. CAMPBELL, M.D., Indianapolis
 WENDELL EDWARDS, M.D., Indianapolis

3. *The Kidney, Renal Arteries and Hypertension*
 Moderator: MYRON H. NOURSE, M.D., Indianapolis
 ERICH K. LANG, M.D., Indianapolis
 B. L. MARTZ, M.D., Indianapolis
 HUNTER A. SOPER, M.D., Indianapolis

4. *Recent Advances in the Therapy of Refractory Heart Failure*
 Moderator: ARTHUR N. FERGUSON, M.D., Fort Wayne
 A. D. DENNISON, Jr., M.D., Indianapolis
 ROBERT B. CHEVALIER, M.D., Indianapolis
 THOMAS E. WOERNER, M.D., Indianapolis
 JACK H. HALL, M.D., Indianapolis

5. *The Management of Coronary Insufficiency*
 Moderator: F. MASON SONES, Jr., M.D., Cleveland, Ohio
 HAROLD F. BURDETTE, M.D., Indianapolis
 JOHN F. LING, M.D., Richmond
 JOHN L. CULLISON, M.D., Muncie

6. *Advancement in the Treatment of Asthma, Bronchitis and Emphysema*
 Moderator: JOSEPH D. HOWELL, M.D., Indianapolis
 WARREN S. TUCKER, M.D., Indianapolis
 RAMON S. DUNKIN, M.D., Indianapolis
 WALTER DALY, M.D., Indianapolis

7. *Hiatal and Diaphragmatic Hernias (Medical-Surgical Treatment)*
 Moderator: HAROLD C. OCHSNER, M.D., Indianapolis
 JOSEPH E. WALTHER, M.D., Indianapolis
 EDWIN R. EATON, M.D., Indianapolis

8. *Treatment of Suppurative Lung Disease*
 Moderator: KARL PFUETZE, M.D., Chicago, Ill.
 DONALD W. BRODIE, M.D., Indianapolis
 GEORGE D. BUCKNER, M.D., Fort Wayne
 DONALD F. MacLEOD, M.D., West Lafayette

9. *Cardio-pulmonary Manifestations of Systemic Disease*
 Moderator: ROBERT K. ALLEN, M.D., Indianapolis
 ROBERT J. YINGLING, M.D., Indianapolis
 JOHN D. GRAHAM, M.D., Indianapolis

10. *Medical, Surgical, and Radiological Management of Bronchogenic Carcinoma*
 Moderator: WAYNE CARSON, M.D., Indianapolis
 JAMES G. ARMSTRONG, M.D., Indianapolis
 JOHN F. DILLON, M.D., Indianapolis
 EVART M. BECK, M.D., Indianapolis

7:30 a.m. Breakfast meeting of the Council, Harrison Room, Columbia Club

7:45 to
9:15 a.m. SECTION ON GENERAL PRACTICE breakfast meeting, East Room, Athenaeum

Election of Section officers for 1965

Round table discussion:

JOHN B. HICKAM, M.D., Indianapolis

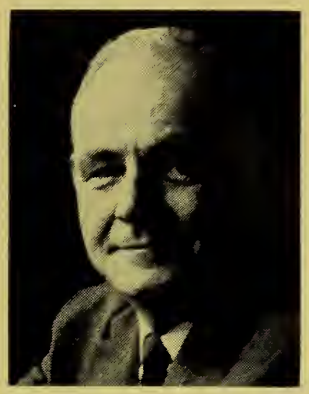
JOHN F. PHILLIPS, M.D., Bluffton

HENRY H. ALDERFER, M.D., Marion

8:30 a.m. Registration continues, lounge room, Murat Temple

8:30 a.m. Technical and scientific exhibits, lounge room, Murat Temple

SPEAKERS



KARL PFUETZE, M.D.
Chicago, Ill.
Clinical Professor of Medicine, University of Chicago, College of Medicine, Chicago, Ill.; General Administrator, Suburban Cook County Tuberculosis Sanatorium District, Hinsdale, Ill.



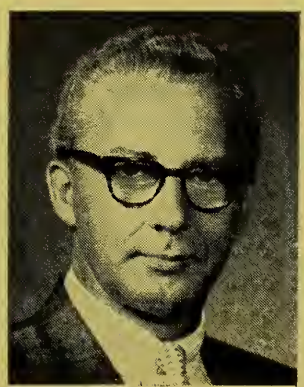
F. MASON SONES, JR., M.D.
Cleveland, Ohio
Head of Department of Pediatric Cardiology, Cardiology Laboratory, Cleveland Clinic Foundation, Cleveland, Ohio



JOHN B. HICKAM, M.D.
Indianapolis
Professor of Medicine; Chairman, Dept. of Medicine, Indiana University School of Medicine; Specialist in internal medicine; M.D. from Harvard University School of Medicine, 1940.



HENRY H. ALDERFER, M.D.
Marion, Ind.
Specialist in internal medicine; Consultant, Veterans Hospital, Marion; M.D. from Jefferson Medical College of Philadelphia, 1943.



JOHN F. PHILLIPS, M.D.
Bluffton, Ind.
Instructor in Cardiology Section, Department of Medicine, I. U. School of Medicine; Specialist in internal medicine (cardiology); M.D. from I. U. School of Medicine, 1944.

Wednesday Morning, October 14, 1964

9:30 to 11:30 a.m. INSTRUCTIONAL COURSES, Egyptian and Candidates Rooms, and Candidates Room Foyer, Murat Temple

9:30 to 11:30 a.m. Continuous MOVIES, Basement Foyer, Murat Temple

Group A:

1. Otoscopy in the Inflammations (Ayerst)
2. Glaucoma: What the General Practitioner Should Know (AMA No. 84)
3. Microbial Susceptibility (Roerig)
4. Medifilm Report No. 5 (AMA, Atlantic City, 1963)
5. Cancer Treated by Arterial Infusion Chemotherapy (Lederle H-27)

Group B:

1. No Real Pathology (Upjohn)
2. The Faces of Depression (Geigy)
3. The Medical Witness (AMA No. 144)
4. Diagnosis and Management of Fungous Infections of the Skin, Hair and Nails (Schering)

Group C:

1. Anorectal and Sigmoidoscopic Examination with Differential Diagnosis (Ayerst)
2. Ligation of the Internal Iliac (Hypogastric) Arteries (Armour)
3. Reduction Mammaplasty for Pendulous Breasts (Armour)
4. Management of Mass Casualties, Part 11: Burns (U.S. Department of the Army Disaster Medical Care Film)
5. Management of Mass Casualties, Part 6: Sorting. (U.S. Department of the Army Disaster Medical Care Film)

Group D:

1. External Cardiac Massage (AMA No. 219)
2. Resuscitation for Cardiac Arrest (Squibb)
3. (B) Head Injury, Grand Rounds #10 (Upjohn)
4. Innovations in Transfusion Therapy (Fenwal)

11:30 a.m. to 1:00 p.m. Time allowed to view technical and scientific exhibits

Wednesday Noon, October 14, 1964

12:00 noon Phi Rho Sigma luncheon, Veterans Room, Athenaeum

12:00 noon Phi Beta Pi luncheon, Blue Room, Athenaeum

12:00 noon Phi Chi luncheon, Ladies Parlors (large room), Athenaeum

12:00 noon Luncheon meeting of the Executive Committee of the Indiana Academy of Ophthalmology and Otolaryngology, Ladies Parlors (small room), Athenaeum

12:00 noon Nu Sigma Nu luncheon, Directors' Room, Athenaeum

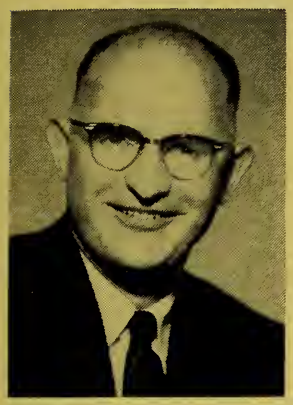
Wednesday Afternoon, October 14, 1964

1:00 p.m. Flying Physicians Association, Indiana Chapter, meeting, Basement Foyer, Murat Temple. (Not a luncheon meeting.)

1:00 p.m. Indiana Bone and Joint Club meeting, Fraternity Room, Athenaeum. (Not a luncheon meeting.)

1:30 p.m. Meeting of small county delegates, Candidates Room, Murat Temple

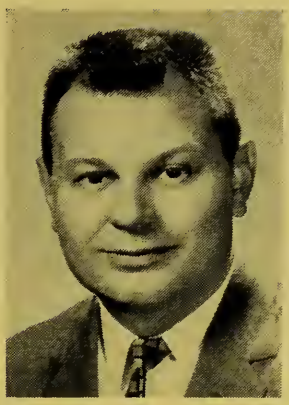
Instructional Course Speakers



RICHARD P. GRIPE, M.D.
Lafayette



FRED H. PRIEBE, M.D.
Indianapolis



EDWARD A. TYLER, M.D.
Indianapolis



JOSEPH ROSS, M.D.
Indianapolis



GEORGE T. LUKEMEYER, M.D.
Indianapolis



RICHARD J. SHELLEY, M.D.
Indianapolis



GEORGE D. BUCKNER, M.D.
Fort Wayne



VICTOR C. HACKNEY, M.D.
Indianapolis



JOHN F. LING, M.D.
Richmond



GLENN W. IRWIN, JR., M.D.
Indianapolis

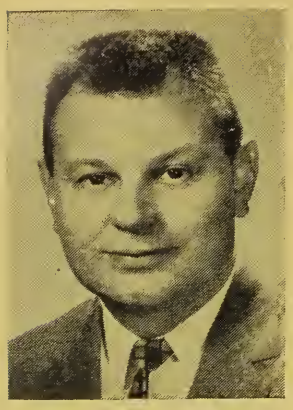
NO PICTURES AVAILABLE

RAY H. BURNIKEL, M.D.
Evansville

HERMAN C. SPRECHER, M.D.
Evansville



SAMUEL T. GIAMMONA, M.D.
Indianapolis



EDWARD A. TYLER, M.D.
Indianapolis

Professor of Psychiatry, Indiana University School of Medicine; Specialist in child psychiatry; M.D. from University of Virginia School of Medicine, 1944.



ROBERT E. SWITZER, M.D.
Topeka, Kansas

Director, The Children's Hospital, The Menninger Foundation; Consultant, the Kansas State Division of Institutional Management in Child Psychiatry, Kansas Neurological Institute; M.D. from I. U. School of Medicine, 1942.



MARIAN K. DeMEYER, M.D.
Indianapolis

Assistant Professor, Department of Psychiatry, I.U. Medical Center; Director, Clinical Research Center for Early Childhood Schizophrenia; M.D. from I. U. School of Medicine, 1952.



JAMES E. SIMMONS, M.D.
Indianapolis

Professor and Coordinator of Child Psychiatry Services, Indiana University Medical Center; Consultant, LaRue D. Carter Memorial Hospital; M.D. from Ohio State University College of Medicine, 1947.

GENERAL MEETING

(Egyptian Room)

Donald E. Wood, M.D., Indianapolis, president, Indiana State Medical Association, Chairman

1:30 to
3:00 p.m. Panel on *Child Psychiatry*

Moderator: EDWARD A. TYLER, M.D., Indianapolis
"Psychiatric Hospitalization of Children—The Family Doctor's Problems in Making this Decision"

Participants: ROBERT E. SWITZER, M.D., Topeka, Kansas
"Problems Related to Real or Imagined Lay Attitude toward Psychiatric Hospitalization"

MARIAN DeMYER, M.D., Indianapolis
"Problems Related to Diagnosis"

JAMES E. SIMMONS, M.D., Indianapolis
"The Treatment Program at Carter Hospital"

EDWARD A. TYLER, M.D., Indianapolis
"Existing Facilities in Indiana"

Question and answer period

3:00 to
3:30 p.m. Time allowed to view technical and scientific exhibits

GENERAL MEETING

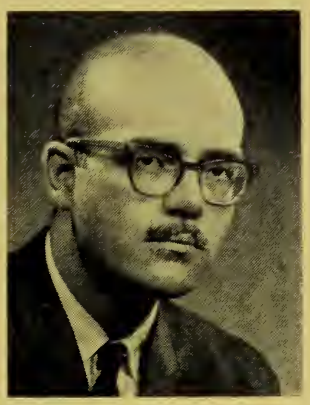
(Egyptian Room)

3:30 to
5:00 p.m. *"Cerebral Vascular Insufficiency"*
Moderator: MARK L. DYKEN, Jr., M.D., Indianapolis

Panel: ELISHA S. GURDJIAN, M.D., Detroit, Michigan
"Surgical Aspects of Treatment of Cerebral Vascular Insufficiency"

JOHN GILROY, M.D., Detroit, Michigan
"Medical Aspects of Treatment of Acute Stroke and Chronic Cerebro-vascular Insufficiency"

JOHN THEODORE LUROS, M.D., Indianapolis
"The Neurosurgeon's Approach to Cerebral Vascular Insufficiency in Private Practice"



MARK L. DYKEN, JR., M.D.
Indianapolis

Associate Professor of Neurology, I. U. School of Medicine; M.D. from Indiana University School of Medicine, 1954.



E. S. GURDJIAN, M.D.
Detroit, Mich.

Professor and Chairman of the Department of Neurosurgery, Wayne State University College of Medicine; M.D. from Wayne State University College of Medicine, 1961.

Wednesday Evening, October 14, 1964

6:00 p.m. Dinner, Indiana Bone and Joint Club, East Room, Athenaeum

Entertainment

8:00 p.m. President's reception and Gaslight Party, Athenaeum



JOHN GILROY, M.D.
Detroit, Mich.

Assistant Professor of Neurology, Wayne State University College of Medicine; M.D. from King's College, University of Durham, England, 1948.

Thursday Morning, October 15, 1964

7:30 a.m. Breakfast meeting of the Council, Ladies Parlors (large room), Athenaeum

8:30 a.m. Registration continues, lounge room, Murat Temple

8:30 a.m. Technical and scientific exhibits, lounge room, Murat Temple

8:30 to
9:00 a.m. Time allowed to view technical and scientific exhibits

The Biggest Fun Event Ever—
Don't miss the

GASLIGHT PARTY

Wednesday, Oct. 14th
8 p.m., Athenaeum

The Chicago Gaslight Club will move to Indianapolis for the evening—Dixieland Music—Gaslight Girls—Your favorite tunes by old time piano players—Plan now to attend—Bring your friends.



HON. R. VANCE HARTKE
Washington, D. C.
Senator from Indiana, member of committees on finance, commerce, the District of Columbia and unemployment problems; Chairman of the Democratic Senatorial Campaign Committee.



HON. D. RUSSELL BONTRAGER
Elkhart, Indiana
Member, Indiana State Senate, Elkhart County, from 1949 to date; Former judge and prosecuting attorney, Elkhart county; Member Elkhart City, Elkhart County, Indiana State and American Bar Associations; Fellow, American College of Trial Lawyers.



ERNEST B. HOWARD, M.D.
Chicago, Ill.
Assistant Executive Vice-President of the American Medical Association; Former Director of the Division of Venereal Disease Control, Massachusetts Department of Public Health; M.D. from Boston University Medical School, 1936.



JOE D. MILLER
Chicago, Ill.
Executive Director of American Medical Political Action Committee (AMPAC); Former Administrator of the Kentucky Tuberculosis Hospitals and member of the AMA Field Staff.

GENERAL MEETING

(Theatre, Murat Temple)

Donald E. Wood, M.D., Indianapolis, president, Indiana State Medical Association, chairman

9:00 to
11:00 a.m. Political-Social-Economic program

HON. R. VANCE HARTKE, Washington, D.C.

HON. D. RUSSELL BONTRAGER, Elkhart, Indiana

ERNEST B. HOWARD, M.D., Assistant Executive Vice-President, American Medical Association, Chicago, Illinois

JOE D. MILLER, Executive Director, AMPAC, Chicago, Illinois

11:00 a.m. to
12:00 noon Time allowed to view technical and scientific exhibits

11:00 a.m. Reception for members of Fifty-Year Club, Foyer, Candidates Room, Murat Temple

12:00 noon President's luncheon, Egyptian Room, Murat Temple

Thursday Afternoon, October 15, 1964

2:00 p.m. Final meeting of House of Delegates, Candidates Room, Murat Temple
Election of officers

Meeting of Council and Executive Committee immediately following adjournment of House of Delegates

Auxiliary Program

Mrs. Herbert L. Egbert, chairman, and Mrs. Harold T. Moore, assistant chairman

Tuesday, October 13, 1964

8:30 a.m. Registration, Murat Temple or Mezzanine, Columbia Club

8:30 a.m. to
4:30 p.m. Hospitality Center, Mezzanine, Columbia Club.
Meet friends over coffee and rolls

Wednesday, October 14, 1964

9:00 a.m. General Assembly meeting, Parlor A, Columbia Club

All members invited

Coffee and rolls

Wednesday, October 14, 1964

9:30 a.m. Meeting starts

11:30 a.m. to
12:30 p.m. Social hour

12:30 p.m. Luncheon and Style Show, Ballroom, Columbia Club

"Artists and Models"

8:00 p.m. President's reception, Athenaeum Gaslight Party, in conjunction with the Indiana State Medical Association

Thursday, October 15, 1964

12:00 noon President's luncheon, Indiana State Medical Association, Egyptian Room, Murat Temple

Convention Arrangements Committees

SCIENTIFIC EXHIBITS: Irvin H. Sonne, New Albany.

MOVIES: Burton E. Scherb, Terre Haute.

WOMEN PHYSICIANS: Martha C. Souter, Indianapolis.

WOMEN'S ENTERTAINMENT: Mrs. Herbert L. Egbert, Indianapolis; Mrs. Harold T. Moore, Indianapolis.

FIFTY-YEAR CLUB RECEPTION: Jerome E. Holman, Sr., Indianapolis.

ART AND HOBBY SHOW: Philip T. Holland, Bloomington.

GENERAL CONVENTION ARRANGEMENTS: Charles Fisch, Indianapolis, chairman; Virgil C. McMahan, Vincennes, vice-chairman; Ray H. Burnikel, Evansville, secretary; Irvin Sonne, New Albany; Merritt O. Alcorn, Madison; Burton E. Scherb, Terre Haute; John Mader, Richmond; James M. Leffel, Indianapolis; Walter J. Aagesen, Anderson; Boyd A. Burkhardt, Tipton; Durward W. Paris, Kokomo; John S. Farquhar, Fort Wayne; Elmer Koehler, Elkhart; Kenneth Kohlstaedt, Indianapolis.

ENTERTAINMENT: Ray H. Burnikel, Evansville, William M. Kendrick, Mooresville, and Mrs. Kendrick.

INSTRUCTIONAL COURSES: Robert B. Chevalier, Indianapolis; Elmer Koehler, Elkhart.

Reports of Officers

Executive Secretary

The past year has produced an intensive and active year in Indiana State Medical Association activities and has presented increased demands upon the officers, the committees and commissions.

At this time I would like to present a brief summary of some of the activities of this association.

To try and include in this report all of the accomplishments and activities of this association during the past year would be somewhat redundant since most of the actions of the association are spelled out in the reports of the commissions and committees to this House of Delegates, and in addition have been distributed to all county medical societies throughout the past year.

However, behind all of these accomplishments, which are the outgrowth of many hours of voluntary labor through meetings by the many physician members who participate on the committees and commissions, is the responsibility of administering and directing the endless details of operation which go with the conduct of all the established programs and the inauguration of new ones.

The secretary and his staff extend to all the hard working physician members their sincere appreciation for the contributions which they have made to their association and for the many kindnesses extended to the members of our staff.

Some of the highlights of this year's accomplishments by the association are as follows:

The initiation of a preceptor training program, which, in conjunction with Indiana University School of Medicine, will get under way before the end of this year. This program is being inaugurated by the Commission on Medical Education and Licensure.

Plans have been made for a TV classroom on Medical Self-Help Training programs. The films for this 15 program series have been purchased through the joint efforts of the Commission on Public Information, the Commission on Governmental Medical Services and the Indiana State Board of Health. It is anticipated that more than 15,000 people will enroll for this course, sponsored by these groups over Indiana television stations.

Emergency medical identification programs and publicity were participated in by the *Indianapolis Star* and the association. In supplying more than 500 of the identification cards and information on the symbols, the association has participated in a meaningful public information and community service program.

Relationships have been strengthened and greater understanding is being promulgated between the association and the voluntary health agencies through the efforts of the Commission on Voluntary Health Agencies.

Greater impetus was given to public information and public relations through the efforts of your president, Dr. Don E. Wood, who has participated in endless contacts with groups and organizations throughout Indiana and the nation. The Public Information Commission has also utilized its efforts toward many new public relations programs.

An aggressive and continuing legislative program, though this has not been a legislative year, has keynoted all activities of the Commission on Legislation.

Planning for the future of the association is under way in a new special committee, chaired by past-president Maurice E. Glock, M.D. This committee shows promise of doing much in setting guide lines for the future growth of the association.

The Commission on Public Health, in addition to its many other responsibilities, held a most successful Junior-Senior Day Program, at which time medical students were given an opportunity to have their questions answered concerning the private practice of medicine and practice in rural communities.

The Commission on Inter-Professional Relations has been active in advocating the inauguration of the new program on medicine and religion by county societies.

The activities of the Commission on Medical Economics and Insurance and the Ad Hoc Committee on Transfer of Professional Services from Blue Cross to Blue Shield and the action of the Council has embarked this association upon a project of importance which will require the understanding and time of many individuals before completion.

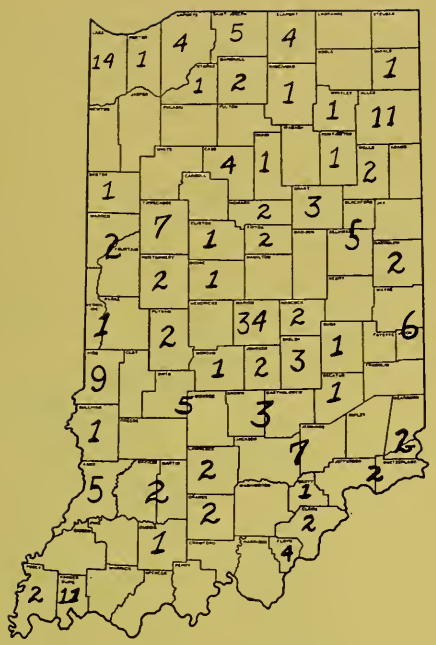
Of course, these are but a few of the programs which have been initiated by the commissions and represent only a small percentage of the programs which have been discussed by these commissions and committees, as well as the Council and Executive Committee.

As stated before, reports of all these activities are made to the membership through their county medical societies and sometimes an action is summed up in a single paragraph, but more often than not, this single paragraph has been the result of many hours of long deliberation and thought by members, giving of their time, which might otherwise be free for them to spend with their families. Through their efforts and the many programs and opinions on many issues which come before them, it is your secretary's belief that the association has represented you and the members of your society, in an effective manner to future physicians and, consequently, the future of medicine, to the people of Indiana and to your associates and colleagues.

The number of physicians from each local society serving on a commission, committee, the Council and Executive Committee of the association are indicated on Map 1.

New Members

During the nine months beginning November, 1963, the association has welcomed 82 new physicians into membership. While this represents a healthy growth, if we are to meet projection of Indiana population and physician need for 1970,



MAP 1

NUMBER of physicians from each society serving the members in an official capacity.



MAP 2

NUMBER of visits to county societies made by field staff from January 1 to August 1, 1964.

our growth must really accelerate during the next five years. Projection indicates that we will need 6,000 practicing physicians by 1970 to maintain the physician-population ratio.

Field Service

The association is fortunate in having two dedicated field representatives who have accelerated their pace of activity during the past year. From the period of January 1 through August 1, 1964, the staff has made 369 calls primarily on physicians and legislative candidates. These visits also included medical society meetings, hospital staff meetings and other special meetings of a medical or health nature. The purpose of the field visits is to keep the membership informed and in contact with the activities of the Executive Committee, Council, headquarters office and programs and policies developed by the various commissions and committees. In addition to keeping the membership advised throughout the state, the field staff has channeled to the headquarters office hundreds of individual requests for information or service. Through the field service, too, the officers of your association are kept alert to attitudes and needs of individual members, which in many instances have guided your officers in formulating decisions on specific problems.

Map 2 indicates the number of field visits made into each county by the field staff for the period of January 1 to August 1, 1964.

Demands upon field services have increased many fold over the past several years and at times it is almost impossible for the staff to fulfill the requests made of them. Some societies desire the field representatives present at all of their society meetings and others have expressed their wish for the field representatives to appear at their society meetings more often than is now possible.

To illustrate the participation of the field men making contacts with county societies, Map 3 illustrates society monthly meeting dates on record



MAP 3

COUNTY society monthly meeting dates on record in headquarters office.

in the headquarters office. Ten societies meet on the second Tuesday of each month, constituting most meetings for a single day. Unmarked areas indicate counties with no monthly meeting date on file with the headquarters office.

Medicare

The administration of the Medicare program also continues to show growth. For the first

seven months of 1964, total claims handled were 6,258, compared to 5,506 for the same period in 1963. We still are experiencing a high percentage of claims which are necessarily returned for additional information. Almost 50% of all claims received have to be returned.

Payments to physicians for the first seven months of 1964 under this program and paid through your headquarters office amounted to $267,594.03, an increase of about nine percent over the preceding year.

Building Operation

The use of the building is continuing to show much increased activity, with the first six months of this year seeing over 30 meetings having been held in the building, with a total attendance of over 800 people.

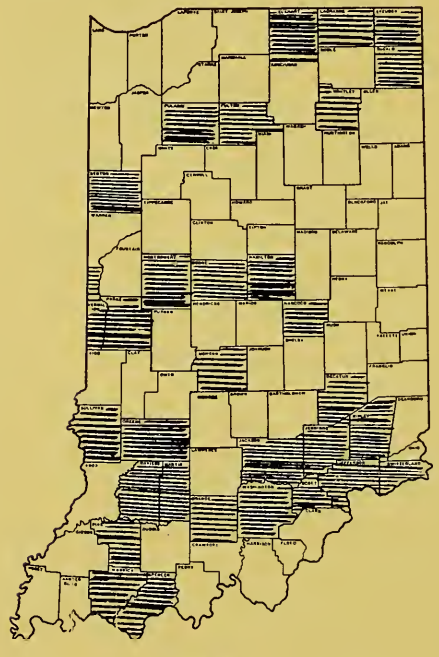
It may be of interest to the membership to know that in conducting all of the association meetings in the building, and feeding the committees and commissions, Council, etc., we have been able to do this on an average cost of about $1.50 per person. When one considers before the advent of the building, we were paying an average of $3.00 per person per feeding, we have been able to provide for greater economy and more efficiency in the handling of commission and committee activities of our association.

County Societies

To pictorially illustrate some of the other activities of your association's headquarters, which is charged with the carrying out of policies dictated by the House of Delegates, the Council and the Executive Committee, we have shown in Map 4 the county societies which have complied with the provisions of the Constitution and Bylaws by filing a copy of same in the headquarters office.

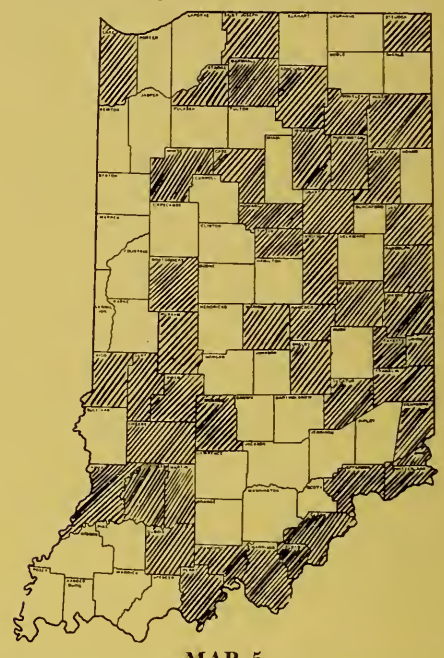
The darkened areas indicate county societies which did not, as of August 1, 1964, have a copy of their Constitution and Bylaws on file in the headquarters office.

Another pictorial illustration that might be of interest is Map 5 indicating the counties which have reported their having a public relations committee to the headquarters office.



MAP 4

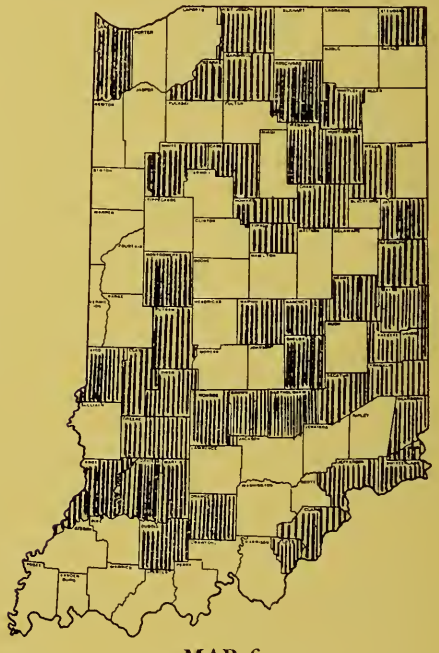
COUNTY societies which have filed a copy of their constitution and bylaws with the headquarters office (white areas).



MAP 5

COUNTY societies which have reported having a public relations committee (shaded area).

The following map indicates the county societies which have reported having legislative committees to the headquarters office.



MAP 6

COUNTY societies which have reported having a legislative committee (shaded area).

Executive Secretary

Your executive secretary has, during the past ten months, represented your association in 174 meetings and conferences.

In addition, your secretary was re-elected secretary of the Conference of Presidents and Other Officers of State Medical Associations, and will participate as a group leader in the AMA Mental Health Congress in November. He will present a paper on conventions attendance at a meeting of the Medical Society Executives' Association the latter part of August, and will address a Conference of Journals in Baltimore on "Tax Liability of Journal Operations." Combined with all this activity are many other activities of the association, which include, in part, a series of Mental Health Conferences, the AMA Conventions—and add to this Indiana State Medical Association Convention planning, records of membership, files, *Journal* publication, Medicare administration, field service direction, office management, continuous liaison with other organizations, physician placement, student loans, requests from individual members, the public, and other organizations, and you will have before you the framework of this association.

Headquarters Office Operation

I feel certain that with your review of the reports of the commissions, the Council, the Executive Committee, and the other committees of the association, you will concur with me that it has been a busy year with many accomplishments. These accomplishments have been made possible only through the dedication of the physician members of these various groups and devotion of your headquarters personnel in carrying out their various responsibilities.

The decision last year to give your secretary an assistant, Mr. Kenneth Bush, has been of utmost value in carrying on these many and varied responsibilities.

It is my personal hope that during the forthcoming year that each member of the House of Delegates will assist the association in implementing the recommendations of the commissions in his respective county medical society. It is also my personal hope that, as a delegate, you will encourage the officers of your county society and your colleagues to feel free to make suggestions to the various commissions and committees of your association.

We face trying times in the legislative halls of Congress and we face a busy year with the convening of the Indiana General Assembly in January, 1965.

Through a strong county medical society structure and with the understanding and cooperation of every member being active in his local society, the purposes of organized medicine will be strengthened to the ultimate benefit of the entire profession in Indiana.

I would like to add to this report my personal appreciation to the loyal, hard working members of my staff for their willingness and devotion to duty which they have displayed during the past year.

JAMES A. WAGGENER, *Executive Secretary*

Treasurer

Following is an itemized statement of the securities in the Building Fund, General Fund and the Medical Defense Fund as of July 31, 1964.

	Face Value	Market Value
BUILDING FUND		
U. S. Savings Bonds	$ 2,000.00	$ 1,980.00
GENERAL FUND		
U. S. Savings Bonds	8,000.00	7,920.00
U. S. Treasury Bonds	50,000.00	44,531.40
91-Day Bills	40,000.00	40,000.00
Total Investments—Building and General Funds	$100,000.00	$94,431.40
MEDICAL DEFENSE FUND		
U. S. Treasury Bonds	$ 30,000.00	$26,606.40

The Executive Committee and the Council reviewed the investment portfolio of the association at each meeting and, with frequent consultations with the investment department of the bank, $60,000 was invested from the General Fund to cover operating expenses until January 1, 1965, budgeted at $108,446.71. In addition, $20,810.00 was taken from the 1964 dues income and placed in the guaranteed student loan fund, making total investments from the 1964 income of $80,810.00. The financial requirements between now and January 1, 1965, will include annual meeting, $14,673.75; Journal, $7,785.00; building loan retirement, guaranteed student loan fund and AMERF, each $18,910.00 and General Fund, $29,257.90.

Cash balances in the respective funds as shown on the books of the Association as of July 31, 1964:

General Fund	$12,417.75
Medical Defense Fund	2,550.32
Journal Fund	1,543.20
Student Loan Fund	11,502.50
Student Loan Fund (Indiana National Bank)	20,810.00
Building Fund	8,628.94
Kitchen Fund	1,069.28
Total Cash on hand July 31, 1964	$58,521.99

Following is the audit of Wolf and Company, Indianapolis, for the fiscal year ending Sept. 30, 1963.

I. W. WILKENS, M.D., *Treasurer*

INDIANA STATE MEDICAL ASSOCIATION

BALANCE SHEET

September 30, 1963

Exhibit A

ASSETS

General Fund:	
Cash	21,475.83
Note receivable	271.48
Inventory—tape recorders	269.94
Deposits, postage and air travel	804.96
Prepaid expenses	2,603.03

Accrued interest receivable..		569.61	
Due from other funds:			
Student loan fund.....	25,000.00		
The Journal	1,499.82	26,499.82	
Reimbursement due for Medicare expenses		1,236.15	
Investment in United States obligations at cost, plus amortization (Notes 1 and 3):			
Treasury bonds	54,948.18		
Savings bonds	10,000.00		
	64,948.18		
Amortization of premium and discount (net)	38.10	64,986.28	
Savings and loan shares (Note 2)		40,133.32	
Fixed assets:			
Office furniture and equipment	60,514.94		
Less accumulated depreciation	17,273.38	43,241.56	202,091.98
Building Fund:			
Cash		1,079.20	
Fixed assets:			
Building	295,799.02		
Less accumulated depreciation	8,782.41	287,016.61	
Land		69,187.60	357,283.41
The Jaurnal:			
Cash		830.60	
Accounts receivable:			
Advertising	5,758.99		
Other	249.72	6,008.71	6,839.31
Medical Defense Fund:			
Cash		2,798.69	
Accrued interest receivable..		244.28	
Due from general fund.....		837.50	
Investment in U. S. Government obligations at cost, less amortization:			
Treasury bonds	25,262.93		
Savings bond	1,000.00		
	26,262.93		
Less accumulated amortization	89.47	26,173.46	30,053.93
Student Laan Fund:			
Cash		1,924.77	
Notes receivable		39,383.17	41,307.94
Medicare Fund:			
Cash		36,780.05	
Recaverable payments to dactars		38,102.95	
Unbilled to doctors		117.00	75,000.00
			712,576.57

Notes:

1. General fund investments in United States obligations aggregating $2,000.00 have been allocated to the building fund.
2. Savings and loan shares, including interest in the total amount of $40,133.32, have been allocated far the purpose of liquidating the obligation to the American Medical Education Fund.
3. General fund investments in United States obligations in the principal amount of $20,000.00 are being held in escrow by the U. S. Government to secure funds advanced for the Medicare Fund.

LIABILITIES AND FUND SURPLUS

General Fund			
Liabilities:			
Accounts payable		1,713.05	
Accrued payroll taxes ...		296.10	
Payable to other funds:			
American Medical Education Fund	37,770.00		
Medical defense fund ..	837.50	38,607.50	
Deferred income:			
Exhibitors' deposits	17,160.00		
Unearned dues	29,392.69	46,552.69	
Deposits on tape recordings		404.50	
		87,573.84	
Fund surplus (Exhibit B).....		114,518.14	202,091.98
Building Fund			
Liabilities:			
Loans from members		24,475.00	
Notes payable—bank		63,000.00	
Performance deposit in escrow		500.00	
		87,975.00	
Fund surplus (Exhibit B)....		269,308.41	357,283.41
The Journal			
Accounts payable—trade		5,267.84	
Accrued payroll taxes		71.65	
Due ta general fund		1,499.82	6,839.31
Medical Defense Fund			
Fund surplus (Exhibit B).....		30,053.93	30,053.93
Student Loan Fund			
Due to general fund		25,000.00	
Fund surplus (Exhibit B)....		16,307.94	41,307.94
Medicare Fund			
Funds advanced by U. S. Government (Note 3) ..		75,000.00	75,000.00
			712,576.57

STATEMENT OF FUND SURPLUS

For the Year Ended September 30, 1963

Exhibit B

General fund:		
Balance, September 30, 1962		150,002.94
Excess of revenues over expenditures (Exhibit C)	2,593.83	
Assets transferred from building fund	35,048.00	
Received from Medicare—prior period expense refund	1,126.97	38,748.80
		188,751.74
Loss on bonds called and sold	506.51	
	31,402.91	
Proceeds of matured bonds transferred to building fund	60,000.00	
Deficit transferred from The Journal	13,727.09	74,233.60
Balance, September 30, 1963		114,518.14
Building fund:		
Balance, September 30, 1962		228,284.40
Revenues:		
Dues allocated	18,902.50	
Donations from members	6,835.00	
Special donations	94.00	

Proceeds of matured bonds transferred from general fund		60,000.00	
		85,831.50	
Less:			
Depreciation on building	5,870.20		
Interest on bank loan	3,889.29		
Assets transferred to general fund	35,048.00	44,807.49	41,024.01
Balance, September 30, 1963			269,308.41
The Journal:			
Balance (deficit), September 30, 1962			(9,259.16)
Excess of expenditures over revenues (Exhibit D)			4,467.93
			(13,727.09)
Deficit transferred to general fund			13,727.09
Balance, September 30, 1963			—0—
Medical defense fund:			
Balance, September 30, 1962			30,764.99
Excess of expenditures over revenues (Exhibit E)			711.06
Balance, September 30, 1963			30,053.93
Student loan fund:			
Balance, September 30, 1962			15,900.07
Interest earned		368.87	
Donation received		39.00	407.87
Balance, September 30, 1963			16,307.94

STATEMENT OF REVENUES AND EXPENDITURES

Exhibit C

For the Year Ended September 30, 1963
GENERAL FUND

	Actual	Budget	Actual Over (Under) Budget
Revenues:			
Dues	226,239.51	205,865.00	20,374.51
Less dues allocated:			
The Journal	30,165.00	31,096.00	(931.00)
Medical defense fund	4,737.75	4,611.25	126.50
Building fund	18,902.50	18,445.00	457.50
American medical education fund	37,760.00	36,890.00	870.00
	91,565.25	91,042.25	523.00
Dues available for operations	134,674.26	114,822.75	19,851.51
Interest on investments	2,972.71	2,400.00	572.71
Received from A.M.A.	1,640.45	1,000.00	640.45
Net income—annual meeting	1,752.20		1,752.20
Contribution — women's auxiliary	1,250.00		1,250.00
Miscellaneous	15.50		15.50
Total revenues	142,305.12	118,222.75	24,082.37
Expenditures:			
Committees and commissions (Schedule C-1)	16,049.09	17,000.05	(951.46)
Officers and council (Schedule C-2)	17,763.34	21,390.00	(3,626.66)
Headquarters office (Schedule C-3)	97,605.11	97,038.00	567.11
Women's auxiliary	1,000.00	1,000.00	
Donations	103.00	500.00	(397.00)
Employes' retirement fund	7,210.75	7,500.00	(289.25)
Total expenditures	139,731.29	144,428.55	(4,697.26)
Excess of revenues over expenditures (expenditures over revenues)	2,573.83	(26,205.80)	28,779.63

STATEMENT OF OPERATING EXPENDITURES

Schedule C-1

For the Year Ended September 30, 1963
COMMITTEES AND COMMISSIONS

	Actual	Budget	Actual Over (Under) Budget
Standing committees:			
Grievance	200.57	250.00	(49.43)
Student loan	62.65	100.00	(37.35)
Commissions:			
Constitution and by-laws	204.71	250.00	(45.29)
Interprofessional relations	218.56	50.00	168.56
Legislation	7,569.04	7,000.00	569.04
Public health	1,092.30	1,100.55	(8.25)
Public information	2,451.26	2,500.00	(48.74)
Special activities	516.68	500.00	16.68
Voluntary health agencies	778.60	750.00	28.60
Medical economics and insurance	900.48	1,000.00	(99.52)
Medical education and licensure	479.79	700.00	(220.21)
Building		100.00	(100.00)
Governmental medical services	743.39	1,200.00	(456.61)
Aging	831.06	1,500.00	(668.94)
Total	16,049.09	17,000.55	(951.46)

Schedule C-2

OFFICERS AND COUNCIL

	Actual	Budget	Actual Over (Under) Budget
President	1,354.25	1,500.00	(145.75)
President elect	226.98	500.00	(273.02)
Council chairman	266.35	300.00	(33.65)
A.M.A. delegates	7,629.63	11,440.00	(3,810.37)
A.M.A. meetings	3,214.91	2,500.00	714.91
Treasurer, auditing and accounting	1,300.00	1,500.00	(200.00)
Council travel	969.08	1,250.00	(280.92)
Council meetings	839.52	750.00	89.52
Better Business Bureau	150.00	150.00	
Chamber of Commerce	1,000.00	1,000.00	
Executive committee meetings	520.29	400.00	120.29
Executive committee travel	292.33	100.00	192.33
Total	17,763.34	21,390.00	(3,626.66)

Schedule C-3

HEADQUARTERS OFFICE

	Actual	Budget	Actual Over (Under) Budget
Salaries	59,048.09	61,700.00	(2,651.91)
Supplies	1,825.38	2,200.00	(374.63)
Telephane and telegraph	6,153.01	4,500.00	1,653.01
Pastage	3,499.80	3,000.00	499.80
Printing and statianery	1,061.79	1,750.00	(688.21)
Travel and entertainment	7,367.33	10,000.00	(2,632.67)
Building aperatian and utilities	4,344.27	7,288.00	(2,943.73)
Organization memberships	509.50	450.00	59.50
Insurance:			
Haspitalization	983.48	1,100.00	(116.52)
Other	3,580.93	1,800.00	1,780.93
Extra help	57.25	500.00	(442.75)
Payrall taxes	1,798.21	1,750.00	48.21
Maintenance—office machines	646.96	500.00	146.96
Depreciatian	6,453.54		6,453.54
Unallocated	275.57	500.00	(224.43)
Tatal	97,605.11	97,038.00	567.11

Exhibit D

STATEMENT OF REVENUES AND EXPENDITURES
For the Year Ended September 30, 1963
THE JOURNAL

	Actual	Budget	Actual Over (Under) Budget
Revenues:			
Subscriptians:			
Members	30,165.00	31,096.00	(931.00)
Nonmembers	996.00	712.00	284.00
Advertising	33,403.69	40,500.00	(7,096.31)
Other	5,566.83	5,500.00	66.83
Tatal revenues	70,131.52	77,808.00	(7,676.48)
Expenditures:			
Salaries (including extra help)	13,625.60	13,300.00	325.60
Office expense and pastage	554.86	600.00	(45.14)
Printing and reprints	49,072.41	54,500.00	(5,427.59)
Engravings	3,602.84	3,400.00	202.84
Travel and meetings	1,500.00	1,550.00	(50.00)
Bulk mailing	1,136.34	1,100.00	36.34
Other publishing expense	550.50	600.00	(49.50)
Payroll taxes	527.83	500.00	27.83
Employe graup insurance	150.48	140.00	10.48
Rent and electricity	3,408.03	3,840.00	(431.97)
Telephane and telegraph	405.11	400.00	5.11
Unallacated	65.45	150.00	(84.55)
Tatal expenditures	74,599.45	80,080.00	(5,480.55)
Excess af expenditures over revenues	4,467.93	2,272.00	2,195.93

Exhibit E

STATEMENT OF REVENUES AND EXPENDITURES
For the Year Ended September 30, 1963
MEDICAL DEFENSE FUND

Revenues:		
Transfer of applicable partian af dues	4,737.75	
Interest earned—U. S. Treasury bands	1,067.05	
Amartizatian—U. S. Treasury bands	64.11	
Prafit an sale af band	31.09	
Tatal revenues		5,900.00
Expenditures:		
Malpractice fees	3,821.06	
Legal fees	2,790.00	
Tatal expenditures		6,611.06
Excess of expenditures aver revenues		711.06

Exhibit F

STUDENT LOAN FUND

Cash balance, September 30, 1962		636.69
Revenues:		
Callection af student laans	6,530.21	
Interest earned	368.87	
Contributions received fram dactars	39.00	6,938.08
		7,574.77
Expenditures—laans to students		5,650.00
Cash balance, September 30, 1963		1,924.77

Chairman of the Council

The Council has experienced a year in which it has been called upon to review many developments and make many decisions which have bearing upon the health of the people of our state and the practice of medicine. The Council has had many individuals appear before it to discuss their projects and findings and to solicit the support of Indiana medicine for their causes.

It is evident from many of the matters which have come before your Council that the individual physician is not always fully aware of, nor informed on, the important work of the Council. It is a difficult task to conduct a communication system which will make every member as well informed as those who regularly attend Council meetings. We have attempted to improve this flow of information by sending minutes of the Council meetings to the component societies. The Council minutes have also been published in *The Journal*, as has always been done.

A new feature has been added to the agenda within the last year. The headquarters office has attempted to obtain background information and reports on any matter to come before the Council. This information has been bound into an agenda for each member which has grown almost to book size. I feel this has been beneficial to members of the Council as they have the history or an outline of the project in their hands prior to the Council meeting for review and discussion with their colleagues.

I think there are but few members who are not fully aware that the association faces some trying times. There is no doubt that the members of the association will be called upon in future months to sacrifice even more of their time and money for the preservation of their medical practice and the principles of a free society.

The Council met in its first regular session at the close of the House of Delegates meeting on October 17, 1963. At this time, by secret ballot, I was elected chairman of the Council for the year and Dr. Ralph V. Everly of Indianapolis and Dr. George Willison of Evansville were named to the Executive Committee. The Council also approved putting a review committee into operation, as sug-

gested in the remarks of the retiring president, Dr. Maurice Glock.

Special Meeting, November, 1963

The Council held a special meeting in November to clarify and resolve problems of policy and procedure between the Indiana State Medical Association and Mutual Medical Insurance, Inc.

On behalf of the Indiana State Medical Association, the Council elected to exercise the prerogatives of the association as outlined in the Bylaws of Blue Shield.

Midwinter Meeting, January 12, 1964

The Council met for its regular midwinter meeting January 12, 1964, with a full attendance. The new councilors and alternate councilors were welcomed and the chairman explained the operation of the Council for the information of the new men.

The Council noted the continuing difficulty in obtaining dates for district meetings — particularly the duplication of several meetings on the same date which makes it impossible for officers of the association to attend. A continuing program has been carried on through all the meetings of the Council this year to try and arrive at a solution to this problem.

The recommendation of the Executive Committee was approved for humidification of the headquarters building.

The Council received a report from the State Board of Medical Registration and Examination to the effect that they were studying possible changes on revisions regarding temporary medical permits and endorsements and inviting a representative of the association to meet with them on January 14th.

The Building Committee's recommendations for use of the headquarters building by outside groups was approved.

Dates were established for the 1967 annual meeting for Indianapolis on October 10, 11 and 12. Other convention dates and places are:

1964—Indianapolis, October 13, 14 and 15.
1965—Indianapolis, October 12, 13 and 14.
1966—French Lick, October 10, 11 and 12.
1967—Indianapolis, October 10, 11 and 12.

The Council received a report concerning the new Indiana Health Facilities Planning program. It was decided that the association would back the present program of the State Board of Health rather than this new project.

The Council authorized the acquisition of additional real estate for possible future expansion of the headquarters facilities, if adequate property became available.

The Commission on Constitution and Bylaws was directed to study the advisability of utilizing the services of past presidents by appointing them to membership on the Council or the Executive Committee.

Renewal of membership in the Indiana State Chamber of Commerce was approved.

Reports were received from the president, president-elect and delegates concerning the interim meeting of the American Medical Association.

The editor of *The Journal* reported on efforts to further reduce the expense of publishing *The Journal*. A contract was signed with a new printer to become effective January 1, 1964.

Reports of the treasurer and the budget committee were received.

A request that industrial firms be solicited for support of the student loan program was turned down. The agreement between the association and the Indiana National Bank for the beginning of the guaranteed student loan program was approved.

The report of the Commission on Convention Arrangements was given, outlining their plans for the 1964 annual meeting.

The Council approved the payment of an honorarium plus travel expenses for out-of-state speakers appearing on the scientific program.

A report was given by the Liaison Committee with Blue Shield and Dr. Lowell I. Thomas was nominated to fill the vacancy on the Blue Shield Board created by the death of Dr. Walter L. Portteus.

Dean John D. Van Nuys spoke on accreditation examination of the Indiana University Medical School and a survey of future needs of medical education in the state of Indiana as called for in the resolution adopted by the 1963 House of Delegates.

Dean Van Nuys reported on the university teaching hospital and discussed the problems of keeping Indiana medical graduates in Indiana. He also reviewed the lack of applicants from rural communities for entrance in the Indiana University Medical School.

The Commission on Medical Education and Licensure was instructed by the Council to develop programs for high schools to encourage students to enter medical school.

Dr. A. C. Offutt, State Health Commissioner, appeared before the Council and stated he would be a delegate from the United States to the World Health Organization meeting in Switzerland. He reviewed the new licensure program for health facilities which went into effect January 1, 1964 and presented a proposal for a tuberculosis eradication program which had been worked out jointly between the state medical association, the tuberculosis association and the board of health. This program outline was given to the Council for their study prior to making a final decision on it. Dr. Offutt also discussed the Health Facilities program as conducted by the State Board of Health.

The Council approved the action of the State Board of Health in sustaining their disapproval of the use of a sulfa preparation instead of silver nitrate in the eyes of the newborn.

A report was heard on the negligence of a county health officer which was referred to the Grievance Committee.

The Council received the membership report as of the close of 1963 and noted the association had a net gain of 31 members.

The Council nominated Dr. John W. Beeler of Indianapolis and Dr. William E. Bayley of Lafayette to succeed themselves as members-at-large on the Blue Shield Board. A report was received on district nominations for membership on the Blue Shield Board as follows:

J. M. Black, M.D., Seymour, District 4

Glen V. Ryan, M.D., Indianapolis, District 7

Milton B. Gevirtz, M.D., Hammond, District 10

Edward G. Dovey, M.D., Elkhart, District 13

Dr. Dennis S. Megenhardt reported as liaison member of the Blue Cross Board.

The Council was notified that Dr. Edward A. Annis, president of the AMA, would be principal speaker at the Indiana University Alumni meeting to be held May 20th.

Spring Meeting, April 26, 1964

The spring meeting of the Council was held on April 26th at the Headquarters building with a full attendance. The Council took the following actions:

Dr. Joseph Black announced that he had resigned as Councilor of the 4th District and was informed his successor would be elected at the business meeting on May 13th.

A request from a county medical society that the Association review and study the Indiana Medical Licensing Law was referred to the Commission on Legislation.

The Executive Committee chairman reported that Dr. George Willison had resigned as a member of the Executive Committee; the Council filled this vacancy with the election of Dr. G. O. Larson of LaPorte.

A discussion was held on the advisability of holding the final meeting of the House of Delegates at the headquarters building and it was decided this would not be feasible.

The Council received a report from the ad hoc committee on the transfer of professional services from Blue Cross to Blue Shield, together with a copy of a resolution on this subject as adopted by the Tennessee Medical Association. The legal counsel was instructed to make a study of the report and to report to the Council the estimated expense for litigating this matter, if this becomes necessary. The committee was also instructed to make an effort to estimate the expense involved in the transfer of these services.

The Council received a request for a $500.00 contribution to the Science Fair which was turned down as most of the county societies support this project on a local basis.

A report was received on the efforts of chiropractors to broaden their services and increase their influence and their attempt to purvey their services under the Workmen's Compensation Laws.

The Council voted to support Dr. Don E. Wood of Indianapolis as candidate for president-elect of the AMA.

Officers of the association gave their reports and the Commission on Public Health was complimented for its outstanding Junior-Senior Day program.

The Council received reports from delegates to the AMA.

A complaint was received from a physician concerning the AMA disability program.

The editor of *The Journal* discussed the financial situation of the publication. The Council referred the question of the economic savings, if any, on publication of the roster on a bi-annual rather than an annual basis to the Business Advisory Committee. Dr. Harold D. Lynch, Evansville and Dr. Jene R. Bennett, South Bend, were elected to succeed themselves on the Editorial Board.

A report was received on the expulsion of a member of a county society.

Councilors were reminded that district Blue Shield representatives terms expired and the following districts should nominate a representative for this position: Districts 1, 5, 8, 9 and 12.

A report of the resignation of Dr. Murray DeArmond from the Blue Cross Board was received and Dr. Eugene S. Rifner of Van Buren was named to fill this vacancy.

The Council heard a report by Mr. Guy W. Spring, executive director of Blue Cross, on an increase in rates for direct-pay members which will take effect on July 1, 1964.

A recommendation of the Commission on Medical Economics and Insurance that a psychiatrist be nominated for membership on the Blue Shield Board was brought to the attention of the Council.

The Council received a report from the Student Loan Committee concerning the operation of the student loan program.

The Council Liaison Committee with Blue Shield discussed a recommendation of the Blue Shield Board requesting the Council to review Resolution No. 26 as it might operate for the 100,000 federal employees in Indiana. The Council affirmed that "Resolution 26 adequately covers the federal employee program."

The report of the Commission on Convention Arrangements was received and approval given the outline and recommendations made by the commission.

Announcement was made that the Council on Occupational Health of the AMA would hold a joint meeting with the Indiana State Medical Association during the 1965 annual convention.

The Commission on Legislation discussed legislation which it was currently studying.

Actions of the Commission on Public Health in approving the program submitted by the Board of Health on Areawide Planning for Rehabilitation Services was brought to the attention of the Council. The Council instructed that each member should receive a copy of this plan and action was deferred until the July meeting.

A recommendation was received from the Commission on Aging that medical students be exposed at least once a year to a lecture on gerontology.

A preliminary report from the firm of Booz, Allen & Hamilton was heard concerning their plans and criteria which would be used in studying med-

ical education facilities over the state, both present and future.

The Council approved the tuberculosis eradication program, as previously submitted.

Dr. Dennis Megenhardt, Blue Cross liaison member reported to the Council.

Dr. John I. Nurnberger, acting dean, I. U. School of Medicine, appeared before the Council. Action was taken to recommend to the Hill-Burton Committee of the State Board of Health that it reconsider the decision of necessary financial support this year for the I. U. Hospital expansion program.

The plan for development of a preceptorship program was reviewed and the Council approved the institution of this program as soon as possible.

The enrollment director of Blue Cross - Blue Shield explained the new program for members of the state medical association. The chairman announced this had been approved previously by a mail ballot.

Summer Meeting, July 19, 1964

The summer meeting of the Council was held at the Headquarters building on July 19 with full attendance.

The Council took note of the death of a former Councilor, Harry P. Ross of Richmond, and adopted an appropriate resolution to the Ross family.

The Council received a full report from Dr. Lowell I. Thomas, chairman of the Ad Hoc committee on transfer of services from Blue Cross to Blue Shield, and reviewed actions of the AMA taken on this subject at the June meeting in San Francisco. Letters were reviewed from attorneys, setting forth legal opinions on the question. Letters from the Indiana Association of Pathology and the Indiana Roentgen Society were also reviewed. The legal counsel discussed cost of litigating this question. The Council approved employment of legal counsel to litigate this question if it could not be resolved in any other way.

The Council deferred naming of a liaison member of the Council to the Blue Cross Board of Directors until October to replace Dr. Eugene S. Rifner.

Recommendation that the association concur in the outline for the Areawide Planning of Facilities for Rehabilitation Services was approved.

The Council discussed matters which had been referred by the Executive Committee and received reports from the officers, the treasurer and the editor of *The Journal*. Actions taken at the June meeting of the AMA were discussed by the AMA delegates and Dr. Bibler, Indiana's member of the AMA Board of Trustees also spoke.

The membership report was received and it was noted the membership continues to grow.

Re-election of Drs. James W. Denny and Loren H. Martin, of Indianapolis, to three-year terms on the Trust Committee of the Indiana Medical Education Foundation were announced.

The Business Committee of *The Journal* gave a report showing that the cost per copy has dropped from $1.48 to 90½¢ and the cost of publishing the roster on an annual basis has dropped from 55¢ to 26¢.

The editor of the Journal requested the establishment of a foundation trust for *The Journal* to which physicians might leave their estates. The Council instructed the legal counsel to draw up appropriate papers for establishing such a foundation.

The Council approved the suggestion of the president that the association institute awards for individuals who had contributed much to the health of the people of the state.

A report was given by the Student Loan Committee who recommended that part of their unused funds might be used to alleviate the financial position of the association. The report was approved and will be referred to the House of Delegates.

The Council Liaison Committee with Blue Shield reported and the Council instructed the Commission on Medical Economics and Insurance to make a study and evaluate the responsibility and role of the physician on the Blue Shield Board.

The final report of the Commission on Convention Arrangements on the program was approved.

The Commission on Constitution and Bylaws gave recommendations for acceptance of late resolutions. The Council ordered the recommendations distributed to the county medical societies.

The report of the Commission on Medical Economics and Insurance was approved and the Council concurred in the recommendation that medical review committees be established by county medical societies. The commission also recommended that it be permitted to study and present a plan for a disability program to supplement the AMA disability program. The request was approved.

Dr. A. C. Offutt, State Health Commissioner, reported that he had sent out a plan for the eradication of tuberculosis to all physicians.

The Council approved the president naming five members of the Association to a study committee on driver and traffic safety.

Dr. Megenhardt, the Blue Cross liaison representative reported on the reorganization of the officer structure of the Blue Cross plan.

The above report constitutes actions taken by the Council since last year's meeting and at the time of writing this report, a special meeting of your Council has been called for August 30th. The actions as taken at this meeting will be submitted in a supplemental report.

I would like to take this opportunity to express my thanks to the staff of the headquarters office for their help during the past two years I have served as chairman. The entire association is deeply indebted to these conscientious, tireless workers.

I should like also to thank the officers and councilors for their patience and cooperation. These men, and the staff, deserve your highest praise for their unselfish work in your behalf.

K. O. NEUMANN, M.D., *Chairman*

First Councilor District

The First District has had another good year. The annual dinner meeting May 7, 1964, at the Evansville Country Club was well attended by members and their wives. The ISMA was represented by Dr. Frank Ramsey, Editor of *The Journal* and Mr. Robert J. Amick, Field Secretary.

The possibility of establishing a second medical school in Indiana was the subject of an illustrated talk by Col. Marvin Evans, Chairman of the Evansville Council on Medical Education.

Elected as officers were: Dr. Frank W. Oliphant, Mount Vernon, President; Dr. Eugene W. Austin, Evansville, Vice-president; Dr. Wallace M. Adye, Evansville, Secretary-treasurer.

Dr. Gilbert M. Wilhelmus was elected to a three year term as alternate councilor and Dr. George W. Willison was re-elected to a three year term as director of Blue Shield.

A community-wide program for tetanus immunization was carried out this spring by the Vanderburgh County Society, which purchased the vaccine and provided all supplies for several public clinics. More than 4,000 persons attended. A publicity campaign induced others to obtain vaccine at their own physician's office.

Health insurance sponsored by the Vanderburgh Foundation for Medical Care which will provide, in most instances, full payment for physicians' services, based on a relative value schedule, is in the process of being made available by Blue Shield. Other insurance companies are considering participating in the plan.

PATRICK J. V. CORCORAN, M.D., *Councilor*

Second Councilor District

The annual Second District meeting was held May 28, 1964 at the Vincennes Country Club. Dr. Paul Arbogast, district president, conducted the meeting during which there was a general discussion, by the few physicians attending the business session, of the apparent lack of interest at the district level. As has been the recent experience, the home or host county provides the bulk of attendants with few, if any, from the other constituent counties. No conclusion or recommendation was made. Richard Kilborn, assistant to the Executive Director of Blue Shield, spoke on new developments in Blue policies and introduced Herbert Dixon who will assume the duties formerly held by L. E. Converse who is ill.

Joe E. Dukes, M.D., Dugger, was elected president and J. S. Brown, M.D., Carlisle, was elected secretary. The 1965 meeting will be in Sullivan and the 1966 in Washington.

Dr. Joseph Black, president-elect of ISMA, gave an interesting talk on legislative activities at the dinner. The main speaker of the evening was Anthony Lasich, M.D., who gave an informative, provocative discussion on malpractice. With a background as an orthopedist and attorney, he spoke with considerable authority. We were indebted to Merck, Sharpe & Dohme for sponsoring this portion of the program.

Any member having a diagnosis and recommended treatment for district meeting ills should forward same to Dr. Dukes.

E. T. EDWARDS, M.D., *Councilor*

Third Councilor District

The Third District held its annual meeting the weekend of May 9, 1964 at the Colonial Inn near Jeffersonville. This was one of the best meetings the district has ever had, and it was due to the untiring efforts of Dr. George Wolverton, Clarksville; Dr. Robert McKechnie, Jeffersonville; their wives and other members of the ladies auxiliary. Many, many hours of detailed planning went into this program which resulted in good attendance and an excellent educational program.

Dr. Morris Weiss of Louisville, a cardiologist, discussed the newer methods of laboratory diagnosis of heart disease. He demonstrated his remote broadcasting electrocardiogram instrument, and had it attached to Dr. Donald Kerr of Bedford while he was playing golf at a nearby golf course.

We then had a period of conviviality, followed by a bountiful meal. The evening was made complete by an address from the Rev. Dr. Paul B. McCleave, director of the Department of Religion and Medicine of the AMA. For those of you who have not heard this man speak about the relationship between religion and medicine, you have missed something worthwhile. I urge you to take every opportunity to hear him whenever he is in this part of the country. Dr. Donald Kerr was elected to succeed me as councilor for the next three years, and Dr. Elmer Wallace, New Albany, was elected to fill the unexpired term as alternate for Dr. Kerr.

The district membership continues to grow slowly. Its been a gratifying thing for me to watch the progress in this district in the last seven years that I have been your councilor. Now as I complete my last report to you as your councilor, I want to thank all of you for the loyal and faithful support that you have given me over the years, and urge you to continue the same support for Don Kerr.

JOHN M. PARIS, M.D., *Councilor*

Fourth Councilor District

The Fourth District Medical Society met May 13, 1964 at the Greensburg Country Club with a good attendance. Officers for the coming year are F. D. Ellis, North Vernon, President; Robert Zink, Madison, Vice-President and S. B. Berkshire, North Vernon, Secretary-Treasurer. Robert Reid of Columbus was elected Councilor to fill the unexpired term of Joe Black of Seymour. Jack Shields of Brownstown was elected alternate councilor.

The Fourth District Medical Society recognized the valuable contribution which Doctor Black made during his term as Councilor for the district and was extremely happy to have him as President-elect of the Indiana State Medical Association.

The district had no serious problems during the year. The 1965 meeting will be held at North Vernon on May 19, 1965.

ROBERT M. REID, M.D., *Councilor*

Fifth Councilor District

Since my report of 1963, the affairs of the Fifth District have proceeded without untoward incident. The Putnam County Medical Society was host to the district last September. Dr. Forrest R. Buell was elected president, Dr. Charles E. Moon, secretary, Dr. V. Earle Wiseman was re-elected councilor and Dr. Alexander W. Cavins was continued as alternate councilor.

The Clay County Medical Society will be host this year. The meeting will be held at Brazil, September 16th. We have been promised refreshments, a barbecue, and a scientific program to be announced soon.

V. EARLE WISEMAN, M.D., *Councilor*

Sixth Councilor District

The Sixth Councilor District Medical Society held its annual meeting May 14, 1964, at the Westwood Country Club in New Castle.

Dr. Donald E. Vivian served as golf chairman for the morning program and a Dutch treat luncheon followed.

The scientific program, held in the afternoon, was arranged by the Henry County Medical Society. Richard Griffith, M.D., Assistant Professor of Medicine from I.U. School of Medicine discussed "Antibiotics, Old and New;" Ernest Fogel, M.D., Associate Professor of Psychiatry from I.U. School of Medicine discussed "Uses and Abuses of Psychotropic Drugs;" J. B. Brook, M.D., Clinical Director of the New Castle State Hospital discussed "Patterns of Epileptic Seizures" and Peter Morgan, M.D., Assistant Superintendent of the New Castle State Hospital, discussed "Clinical Management of Convulsive Disorders."

A short business meeting followed with these officers elected: Dr. Charles Loomis, Richmond, president; Dr. W. E. Murray, New Castle, vice-president; Dr. John J. Farrell, Jr., Greenfield, secretary. Re-elected councilor was Dr. William R. Tindall, Shelbyville.

A social hour was enjoyed by the doctors and their wives before dinner. Auxiliary members had been entertained by the New Castle Auxiliary with Mrs. George Stauffer serving as general chairman.

The after-dinner speaker was Dr. Charles Letourneau, Chicago, President of The Letourneau Associates, who spoke on "Legal Pitfalls in Everyday Medical Practice."

Special guests at the meeting were Dr. O. N. Olvey, Mr. James A. Waggener and Mr. Robert Amick.

WILLIAM R. TINDALL, M.D., *Councilor*

Seventh Councilor District

Dr. William C. Stafford, Plainfield, was chosen president-elect of the Seventh District Medical Society during the organization's annual meeting held Wednesday, May 6, at the Hillview Country Club, Franklin. Dr. Stafford will succeed Dr. Albert M. Donato, Indianapolis, who will serve during 1964-65.

Dr. James H. Gosman, Indianapolis, was re-elected secretary-treasurer of the society.

Preceding the dinner meeting, which was attended by approximately 60 persons, society members and their ladies enjoyed an afternoon of golf and bridge. Dr. Joseph Ferrara, retiring president, conducted the meeting.

ALBERT M. DONATO, M.D., *Councilor*

Eighth Councilor District

The Eighth District Medical Society meeting was held at Linders in Anderson on May 27, 1964, with the Madison County Medical Society serving as host at a social hour for about 50 members, wives and guests.

The meeting was arranged by Dr. William L. Baughn of Anderson, district president and Dr. Robert D. Williams of Markleville, secretary-treasurer. Dr. Williams presided at a short business meeting and the dinner that followed. Dr. Warren Bergwall, Muncie, was elected president and Dr. David Dietz, Muncie, was named secretary-treasurer at the business meeting. Dr. Fletcher McDowell, Muncie, was re-elected for a three-year term on the Blue Shield Board of Directors.

The 1965 District Meeting will be held in Muncie, Indiana on a date to be announced later.

The speaker of the evening was Dr. Carl Martz, Indianapolis, who spoke on the recent Indianapolis Coliseum disaster. He stressed the importance of any medical society having a well developed disaster plan and coordinating it with local police and Civil Defense organizations.

Among the guests introduced by Dr. Williams were Dr. Ralph Everly, Chairman, Executive Committee, and Mr. James A. Waggener, Executive Secretary of the Indiana State Medical Association.

DONALD R. TAYLOR, M.D., *Councilor*

Ninth Councilor District

The Ninth District Medical Society's annual meeting was at Attica, May 21st, 1964, with the Fountain-Warren County Medical Society as host. Dr. Edward Humphrey of Covington served as district president and Dr. P. R. Petrich of Attica served as secretary-treasurer. The Indiana Academy of General Practice Road Show was a co-sponsor of the educational seminar.

The scientific program was noteworthy because of its excellence and its poor attendance. Too many physicians could not resist the lure of the "green pastures" and missed an excellent scientific program. Dr. Emerson Harvey from Delco-Remy discussed "Everyday Problems in our Patients Medicine," and Dr. Lowell H. Steen of Whiting discussed the "Placement of Cardiac Patients in Industry." Both topics were interesting, timely and exceptionally well presented.

At the business meeting (attended by the delegates and only a few members) Dr. P. R. Petrich of Fountain-Warren County Medical Society was elected councilor for a term beginning in October, 1964, succeeding Dr. K. O. Neumann of Tippecanoe County Medical Society. Dr. R. W. Vermilya of

Tippecanoe County was elected as the Ninth District representative on the Blue Shield Board for a term beginning in March, 1965. Dr. Donald Wood, Indiana State Medical Association President, discussed organization matters, and Mr. James A. Waggener, Indiana State Medical Association Executive Secretary, discussed related matters. An invitation was received and accepted to have the annual meeting next year on Thursday, May 20, at Frankfort, with the Clinton County Medical Society as host.

Following a social hour and dinner, 92 members and guests heard Dr. W. W. Bauer, Director Emeritus of Health Education of the American Medical Association, discuss "Health Education and the Public."

The Ninth District has enjoyed a quiet year in 1963-64 and there have been no organizational problems.

Your councilor has enjoyed representing the Ninth District for the past eight years. The support and cooperation of the members, in spite of differences of opinion in some areas, has been gratifying.

K. O. NEUMANN, M.D., *Councilor*

Tenth Councilor District

Two Tenth District meetings have been held since our last report. Dr. F. R. LaFollette, Tenth District president, presided at the October 9 meeting. Ninety-five doctors and wives were in attendance. Minutes of the spring meeting were read and approved.

Dr. LaFollette urged attendance at the October 14th-17th Indiana State Medical Association meeting in Indianapolis. He introduced Mr. Howard Jennings, district manager, Social Security Administration, Gary and Mr. Joseph Harper, district manager, Social Security Administration, Hammond.

A Tenth District election was then conducted with the following results:

President ----------Dr. M. Shellhouse

Secretary ----------Dr. E. J. Dierolf

Alternate Councilor ----Dr. Lee Trachtenberg

Blue Shield Board Member--Dr. M. B. Gevirtz

Dr. Gevirtz's terms is to be consecutive, completing the unexpired term of the late Dr. Harry R. Stimson, and a new full term beginning March, 1964.

Dr. LaFollette then introduced Dr. Edmund Haggard, M.D., Chief Medical Consultant for Disability, who spoke and answered questions on "Disability Determination Problems."

The Tenth District president, Dr. Michael Shellhouse, presided at a dinner meeting May 13 attended by 83 physicians and wives. During dinner, Dr. Shellhouse introduced the various county presidents, the Tenth District councilor and the Tenth District Blue Shield representative.

Dr. Shellhouse introduced Dr. Leo Zimmerman, Professor of Surgery, Chicago Medical School, who spoke on the "Surgical Aspects of Breast Cancer." A question and answer period followed Dr. Zimmerman's presentation.

L. H. STEEN, M.D., *Councilor*

Eleventh Councilor District

As Councilor of the Eleventh Medical District, I wish to thank you for my election to a second term as Councilor. This was done shortly after my last report, and I wish to thank this organization for its confidence in me. I shall do my best to represent the Eleventh Medical District at the Council table, and to look after the best interests of medicine. The Councilor has attended all meetings of the Council including one called meeting.

During this fiscal year of the Council much has been accomplished. One of the highlights of the Council meetings was the called meeting concerning a controversy between the Blue Shield board and the Council of the Indiana State Medical Association. This difference of opinion was resolved. Your Councilor has been the liaison officer between the Blue Cross board and the Council for approximately one year. At the end of this time there was a vacancy on the board and your Councilor was appointed as a member of the Board of Directors. I do not take this task lightly and feel it a rather heavy burden, not from the number of trips that are required, but from the necessity for medicine to be represented by a strong will upon this board. It is hoped by showing the board the interests of medicine that this organization will do more for the cause of organized medicine.

Your Councilor, in the capacity of a member of the Public Health Commission, helped to formulate the program for Junior-Senior Day and has helped to bring this program into being. This was a most successful meeting for which the commission gained a citation from the Council and from the President-elect.

In the past year a more close identification between organized medicine and our Indiana University Medical School has been gained. Preceptorships are in the making.

The committee concerning the transfer of fees from Blue Cross to Blue Shield for pathologists and radiologists is having considerable difficulty. It seems that the problem is one of whether or not the moral issue concerning payment directly to the physician or the economic problems of such payment will win out. At times I feel that the problem is best summed by the small quote "It ain't the principle—its the money." Nevertheless, much effort has been put into this problem. It seems continuous even though the House of Delegates requested this change.

While this report will appear in the convention issue of the state medical *Journal*, it is being written far earlier than that. The state medical organization has attempted to give not only an interesting, but an informative program. Those of you who have attended this convention from the Eleventh Medical District, should urge your members at home to attend. It is hoped by your Councilor that each county has sent in its resolutions.

I would hope that the president of this organization could see fit to have each county read the Resolutions that it has sent before the House of Delegates in order that we as a district might understand why this county or that county within our district has presented such a resolution.

The Councilor wishes to thank the Alternate Councilor, Dr. Lowell Hillis, for his attendance at the Council meetings and for his sage advice and guidance at such meetings. I personally have learned to know him, to understand him, to respect him and to find his thinking extremely clear, precise, and correct. I would have you know that it is through a speech of his at the most recent state medical organization Council meeting that the alternate councilor has been elevated in status and position. Prior to Dr. Hillis' remarks concerning the low stature of the alternate councilor, he was just as Dr. Hillis had described him. Now these men are not considered substitutes in the background, but are considered men of stature from each district whose opinion is sought after.

This is a year of elections. On our national scene within each district, and I am speaking of the Congressional Districts now—not the medical districts—a new man will be offered to us. I think it well that we support the man of our choice and that we as a profession discontinue the attitude that we cannot speak out on political matters. I think it is time that we each do a bit more than just pay our dollars to I-HOPE. I would sincerely urge all of you to do this. But in addition I would urge each and every one of you to support with extreme vitality, with hard earned time, and with bulldog tenacity the representative in your area that you feel is most qualified for the office.

I will not enter into a discussion as to which of the presidential candidates may be chosen. I would urge medicine and individual physicians to fight for the presidential candidate of their choice. I would have them choose this individual according to the following criteria. First, this should be a man who is best for our country. Second, this should be a man who is best for our patients. Thirdly, this should be a man who understands the problems between our patients and ourselves and perhaps third parties. This criteria should be used for all of those who are seeking electoral office.

I think what is good for our patients and is good for our country, will be good for you and me. Each of us is one of the more highly educated individuals within his community. People look to you and me for leadership. In the past medicine has stayed aloof from what it considered the muck and mire of politics only to have that same muck and mire thrown at our face. We can no longer stand in the shadows of the political arenas with a smug face offering no type of leadership, but a "better than thou attitude." We must step up to the pedestal which I described some three years ago and lead our people. They are hungry for your thoughts. No one respects a man who growls after the fight is over.

We may win, we may lose, but the influence of medicine must be shown. If each member of the Eleventh Medical District would talk to one hundred people, the Eleventh Medical District alone would then have influenced nearly 30,000 voters. Don't tell me you don't have time. If we don't see to it that those who are friendly to our cause—and I firmly believe our cause to be good for the country and not a selfish one—then you and I probably will not have time to see patients for paper. Or if we have time, we will be a small voice as a federal employee.

There is nothing in medical ethics that interferes with or contradicts the right of the physician to be a patriotic leader for his country. Awaken, physician, go to work and cure the ills of your country, and perhaps there will not be the mocking words—"Physician heal thyself." The disease we fight is creeping Socialism. The drug of choice is education and understanding of democracy, capitolism and the Free Enterprise System. This drug must be used in large amounts by the medical profession and not in homeopathic doses.

I plead with you to take a little more time from your golf game, a little more time from your fishing, a little more time from your boating and a little more time from any other recreation, apply it with judgment and energy and as a helping catalyst to those men who are fighting the cause of medicine in our halls of legislation.

Your Councilor invites any criticism you may have—be it good or bad. I would have you know that I feel that I am elected to serve this district, and am therefore the servant of the members. I would look with eagerness to an invitation to any of the county societies at any time.

EUGENE S. RIFNER, M.D., *Councilor*

Twelfth Councilor District

The annual meeting of the Twelfth District was held at Cutter's Chalet in Fort Wayne on May 21, 1964. The meeting was chaired by Donald G. Mason, M.D., Angola, president. There were 106 members present. The minutes of the previous meeting were read and approved. The report of the treasurer was accepted as read.

Mr. Richard Kilborn, assistant executive vice-president of Indiana Blue Shield, gave a very interesting report regarding the membership in Indiana. He reported that more than 156,000 persons over age 65, or approximately 45% of our population in that age group, hold membership in Blue Shield. Mr. Kilborn reported Mr. L. E. Converse has retired because of illness and Mr. Herbert Dixon has been selected the new physician relations representative for Blue Shield. Mr. Dixon was introduced.

Mr. Howard Grindstaff, field representative for Indiana State Medical Association, was introduced and gave a short report on the status of the King-Anderson bill and the probable increase in Social Security benefits proposed this year.

I gave the annual report of the Twelfth District councilor and commented on the preliminary report of a study by Booz, Allen and Hamilton, a Chicago

consulting firm, on the further needs for medical education in Indiana. I enumerated and stressed the established criteria for sound expansion of medical education in Indiana and the alternative ways that have been proposed by which the future needs for medical education might be met. The members were informed that on April 26, 1964 a contract between the Indiana State Medical Association and the Indiana National Bank of Indianapolis was signed whereby the bank will administer the Student Loan program of the Indiana State Medical Association. The advantages and some of the mechanics of this arrangement were briefly presented.

Francis Land, M.D., delegate to the American Medical Association, reported on AMA activities stating that, as proposed, the AMA Board of Trustees has now been increased from 12 to 15 members and that each member henceforth will be limited to serve a maximum of nine years. The AMA disability insurance program was discussed as well as the increased AMA facilities in Chicago for the study of birth defects and the effects of tobacco.

Mahlon Miller, M.D., Twelfth District Blue Shield representative, gave a report stating that he had attended all state meetings during the year as well as the national meeting in Hollywood, Florida. Dr. Miller pointed out that claims paid to Indiana physicians as beneficiaries again exceeded monies paid in premiums and therefore an increase in premiums becomes necessary.

Truman Caylor, M.D., Bluffton, I-HOPE representative, brought us up to date on the impact I-HOPE has made upon state and national politics. He made a strong plea for further and increased support of I-HOPE and its projects.

Following each report time was given for questions, answers and discussion.

The last order of business was the election of district officers which resulted in the election of Marvin E. Priddy, M.D., Fort Wayne, president; Fredric Schoen, M.D., Fort Wayne, vice-president; and Warren Niccum, M.D., Columbia City, secretary-treasurer. Mahlon Miller, M.D., was re-elected Blue Shield district representative and I was re-elected Twelfth District councilor.

A proposal to change the month of the annual Twelfth District meeting in 1965 was defeated. The meeting therefore will be held in Fort Wayne on Wednesday, May 19, 1965.

Following a social hour, dinner was served to 130 members and wives. A very interesting after dinner talk, illustrated with moving pictures, was given by Mr. Jim Dooley, line coach of the Chicago Bears football team. A spirited discussion with questions and answers followed.

In a raffle for the benefit of I-HOPE, Mr. Kilborn won a football autographed by the players and coaches of the Chicago Bears, National Football League 1963 Champions. Lucky man!

It is appropriate at this time to thank you for the privilege of having served as your councilor these past three years. I have attended all regular and special meetings of the Council during the last year and Dr. William R. Clark, alternate councilor, has been present as well. His mature advice and judgment, always willingly and freely given, has been of great value. Dr. Clark repeatedly has given evidence of his devotion and dedication to the causes of medicine.

I am deeply grateful for your vote of confidence expressed in May, 1964, when you re-elected me to a second term as councilor. I pledge you full and sincere representation at the Council table.

MILTON F. POPP, M.D., *Councilor*

Thirteenth Councilor District

The annual meeting of the Thirteenth District Medical Society was held in the Hotel Elkhart on September 18, 1963, with the president, Robert Rouen, M.D., presiding. The minutes of the 1962 meeting were read and approved. The treasurer's report was read and approved. The meeting was addressed by Maurice E. Glock, M.D., president of the Indiana State Medical Association. The following officers were elected for the ensuing year:

President—Thomas D. Armstrong, M.D., Michigan City
Vice-President—Guy Ingwell, M.D., Knox
Secretary-Treasurer—Cecil R. Burket, M.D., Bremen
Blue Shield Representative—Edward Dovey, M.D., Elkhart

JENE R. BENNETT, M.D., *Councilor*

The Journal

At the time this report is written the financial report of *The Journal* shows a small surplus. The issue in which this report is published is always larger than average and its cost may produce a small deficiency. Advertising revenue has improved slightly. The deficit, if there is one, will be small due to a favorable printing contract with a new printing firm.

We continue to receive an adequate supply of interesting and well written scientific articles, as well as a good supply of special articles. Our backlog of accepted papers continues to be too large, due to the continued small issues and the high quality of contributions, some of which have been difficult to reject.

During the year Laboratory Medicine has been reinstated, with Dr. Wei-Ping Loh, of Gary, as editor. Other regular and special features such as Electrocardiogram of the Month, Medicine at Law, Path-Finder, X-ray Conference and Medical Panorama have continued. All of these are frequently referred to in a complimentary manner.

A new service feature of *The Journal* is the page which lists the annual meeting dates of specialty and allied medical organizations in the state of Indiana. *The Journal* has also recently adopted the practice of listing the new members of the association who are entering private practice.

The Council at its summer meeting authorized the establishment of an endowment fund, the proceeds of which are to be designated for educational

purposes through the medium of *The Journal*. When the proper legal procedures have been accomplished, announcements will be made and the fund will be ready to receive gifts and bequests.

FRANK B. RAMSEY, M.D., *Editor*

Delegates to AMA

Two Indiana physicians served on reference committees of the AMA House of Delegates at the national organization's annual meeting June 21-25 in San Francisco.

Dr. Guy A. Owsley, Hartford City, served on the reference committee on Public Health and Occupational Health and Dr. Jack E. Shields, Brownstown, on the Reports of Officers reference committee.

James A. Waggener, executive secretary of ISMA, was re-elected secretary-treasurer of the Conference of Presidents and Officers of State Medical Associations.

ISMA delegates, alternate delegates and officers attended the annual meeting.

Tobacco and health, human rights, physician-hospital relations, continuing medical education, the cost of medical care, and federal subsidization of prepayment plans and health insurance companies were among the major subjects acted upon by the House of Delegates.

Dr. Donovan F. Ward of Dubuque, Iowa, vice-president of the association, was named president-elect of the association. He will become president at the June, 1965, annual convention in New York City, succeeding Dr. Norman A. Welch of Boston, who was installed at the inaugural ceremony in San Francisco.

The AMA 1964 distinguished service award was won by Dr. Irvine H. Page, director of research of the Cleveland Clinic, for his investigation of cardiac, vascular and renal disease.

Final registration figures reached a grand total of 49,437, including 14,229 physicians.

Tobacco and Health

The house approved a strong stand on tobacco and health by calling cigarette smoking "a serious health hazard." This action was taken after the reference committee on Public Health and Occupational Health considered 10 resolutions and a Board of Trustees report on the subject and heard considerable testimony.

In adopting a four-point reference committee report, the house said "the American Medical Association is on record and does recognize a significant relationship between cigarette smoking and the incidence of lung cancer and certain other diseases."

It urged that programs be developed to disseminate vital health education material on the hazards of smoking to all age groups through all means of communication. The house also recognized the contribution of the Surgeon General's committee in its comprehensive report. And it emphasized that a joint committee of the AMA and the National Education Association already has adopted a resolution urging elementary and secondary schools to include programs on smoking and health in their health education curricula.

The house further recommended that the AMA pamphlet, "Smoking: Facts You Should Know," should be modified "in the light of accumulating knowledge."

Finally, the house said that the delegates and the Board of Trustees "should take great pride in the establishment of the research program on tobacco and health that is being carried out by the AMA Education and Research Foundation."

In adopting the report of the AMA-ERF the house called attention to the following statement:

"The board of directors of AMA-ERF and the Board of Trustees of the AMA were clearly aware of the possibility of criticism in accepting this grant (10 million dollars from several tobacco companies). But against that possibility they weighed the potential benefits to the public who will continue to smoke and concluded that the risk was insignificant by comparison. The only hope of minimizing the hazards of smoking lies in research which points to the course that the AMA as well as others must take."

Human Rights

On the major issue of human rights the house declared itself "unalterably opposed to the denial of membership, privileges and responsibilities in county medical societies and state medical associations to any duly licensed physician because of race, color, religion, ethnic affiliation or national origin."

This action was taken after the reference committee had heard a detailed discussion and had considered four resolutions on the subject.

In addition, the house called "upon all state medical associations, all component societies, and all individual members of the AMA to exert every effort to end every instance in which such equal rights, privileges and responsibilities are denied."

The house also accepted a report from the board on the liaison committees of the AMA and the National Medical Association. This report reviewed the history of the committees and noted that "great progress has been made voluntarily. More progress can reasonably be expected in the immediate future, especially if the committees are permitted to continue on a constructive, cooperative basis. This requires effort, but more importantly, goodwill and the desire to eliminate problems."

Physician-Hospital Relations

Conclusions and recommendations in a significant and extensive report on physician-hospital relations were adopted by the house. Prepared by the Council on Medical Service's Committee on Medical Facilities, the report stresses "the imperative need for the medical profession to assume responsibility for the quality, continuity, and availability of professional services and for the coordination of these services with the other essential supportive aspects of health care."

The report's recommendations are designed to serve as guidelines for physicians in meeting the

problems involved in the changing patterns of care such as: appointment of salaried chiefs of staff; appointment of salaried heads of clinical departments; appointment of salaried directors of medical education; employment of salaried physicians for outpatient and emergency departments; use of salaried physicians to provide care ordinarily provided by interns and residents; and utilization of closed-panel prepayment medical care programs by hospitals.

The report also includes a review of the development of AMA's policy on physician-hospital relations, a study of the relation of policy to actual practice, and an investigation of the factors influencing change—including graduate education, medical finance, expansion of hospital functions and regulation of medical care.

Continuing Medical Education

Authorization was made by the house to establish an AMA-sponsored survey and accreditation program in continuing medical education. In the program attention will be concentrated on institutions and organizations offering courses rather than on individual courses, and appraisal of an institution's or organization's program will be carried out only at its request.

Eventually, approved institutions or organizations will be so designated in the council's annual lists of "Continuing Education Courses for Physicians," and when all institutions which wish to list their courses for approval, have had the opportunity to be considered for approval, only courses of approved institutions and organizations will be included in the annual list. Programs will be surveyed by a review committee on Continuing Medical Education.

Cost of Medical Care

A four-volume report of the AMA Commission on the Cost of Medical Care was received by the delegates, and the house concurred with the Board of Trustees that the conclusions and recommendations of the commission will be studied and a report will be made to the house for its consideration at the 1964 Clinical Convention.

The four volumes include a general report on factors involved in medical care costs, a full report on "Professional Review Mechanisms," another on "Significant Medical Advances" and one on "Changing Patterns of Hospital Care."

In its report the board said that the commission "is aware that its efforts will not result in a magic reduction in the price of medical and hospital services. It does believe, however, that its study has produced a considerable amount of new and relevant information which will serve as a basis for better understanding by the public and the medical profession of this complex subject."

Reaffirmed the AMA policy favoring federal grants for "bricks and mortar"—funds for construction and renovation of medical schools, hospitals, related institutions and mental health centers—but urged that the "advantages and desirability of multiple source financing be kept clearly in mind." The house also was informed by the board that it is appointing a commission to conduct a broad study of the role of federal support of medical research.

Other Actions

—The house went on record as opposing federal subsidization of prepayment plans and health insurance companies, and it asked for an AMA study of the development of state programs which utilize prepayment plans or health insurance companies in the implementation of state programs of medical aid to the aging under the Kerr-Mills law.

—A proposal to poll all AMA members concerning compulsory Social Security for self-employed physicians was rejected by the house. In addition, the house concurred with the reference committee in opposing polls of the membership on issues of "great or even moderate importance" because the house members express the majority sentiments of their constituents on all questions coming before the house.

—An expanded program on medical ethics was endorsed by the house. The program will be designed to educate physicians and the public on what medical ethics means to them and how medical ethics affects them. The judicial council, working with the Board of Trustees, will determine the means by which this expanded program is to be implemented.

—Approval was given to a change in the bylaws to allow the house to set the hour and day of election of AMA officers at the annual convention. This was adopted early in the house session and made it possible to have the nominations on Wednesday afternoon and the elections on Thursday morning.

—A three-point communications program designed to improve the public relations position of the medical profession was endorsed by the house on recommendation of the AMA Committee on Communications. The program includes a redoubling of efforts by county and state societies, closer liaison with media personnel and prompt information to state societies on AMA news releases and testimony.

Miscellaneous Actions

In considering a wide variety of resolutions and reports, the house also:

Approved the creation of the Section on Allergy on recommendation of the Board of Trustees.

Approved a comprehensive inquiry of the causative factors for the sharp increase in syphilis and gonorrhea and urged the AMA to "take leadership in educational and research measures designed to control and eliminate syphilis."

Okayed a national conference on areawide planning of hospitals and related health facilities, to be sponsored under the auspices of the AMA.

Agreed to continue and broaden studies on the problems of unwed mothers, illegitimacy and other related matters and to develop positive preventive programs.

Supported a position statement on protecting

children against physical abuse and called for legislative guidelines to the states relative to legislation on this matter.

Asked the Board of Trustees to investigate establishment of a wire communications system between AMA headquarters in Chicago and offices of state medical associations.

Referred to the Council on Medical Service a resolution condemning the practice by some hospitals of adopting constitutions which deny staff privileges to physicians not eligible or certified by specialty bodies or societies.

Agreed with the board that a forum for representatives of national medical specialty societies and the American Academy of General Practice be held on Nov. 1, 1964, in Chicago.

Approved a resolution calling for the publication of the proposed nominees for standing committees (councils) of the house be submitted in advance of the annual convention, preferably in the House of Delegates Handbook.

Recommended that the Board of Trustees use the talents of Dr. Edward R. Annis, immediate past-president, and other qualified spokesmen for medicine with appropriate remuneration.

Asked the Committee on Insurance and Prepayment Plans of the Council on Medical Service to consider a revision of simplified health insurance claims forms.

Recommended that the Board of Trustees approve the establishment of an ad hoc study on family practice as proposed by the Council on Medical Education.

Agreed with the change of name of the Council on Medical Education and Hospitals to the Council on Medical Education.

Requested clarification of the ethical and legal limitations of physicians participating in court-ordered, pre-trial psychiatric examinations.

Urged the AMA to continue its vigorous opposition to tax regulations discriminating against "professional associations" and "professional corporations" and its support of legislation which seeks to provide tax equality with business corporations for "professional associations" and "professional corporations."

Opening Session

Dr. Edward R. Annis of Miami, outgoing AMA president, told the special Sunday afternoon opening session that a greater effort is needed in the areas of continuing medical education and health education programs. He also urged state and county medical associations to bolster their paid executive personnel to help carry out local, state and national projects. Doctor Annis called for an increase in AMA dues and later the house referred the question of a dues increase to the Board of Trustees for study and for a report at the 1964 Clinical Meeting in Miami. Honored at the opening session were the presidents of state and territorial medical associations and a number of special AMA guests from national organizations.

At the Monday session awards announced were the AMA Scientific Achievement Award to Prof. Rene Jules Dubos, Ph.D., of the Rockefeller Institute, New York City, and the Joseph Goldberger Award in Clinical Nutrition to Dr. William J. Darby of Vanderbilt University School of Medicine, Nashville.

Inaugural Ceremony

Doctor Welch, in his inaugural address Tuesday night, said that medicine must be united if it is "to serve the public in the future to the high degree that it has in the past." He stressed that American physicians must be "standing strong and firm with a heart and a conscience tuned to public need, with a respect for the rights and privileges of the individual and with an abiding faith in our free competitive system of medical practices."

In keeping with Doctor Welch's address, "Unity in Medicine," presidents or their representatives from 29 medical specialty organizations were honored guests at the ceremony.

The distinguished service award was presented to Doctor Page and the scientific achievement award was given to Doctor Darby.

Wednesday Session

Speaking at the Wednesday session, Doctor Welch pointed up the growing alliance between medicine and research—an alliance rooted in truth, knowledge and the freedom to search them out. He called these "the greatest assets available for human development and human well-being." Doctor Welch also enumerated the important projects of the AMA in the past years such as mental health, continuing medical education, tobacco and health, and AMA-ERF, the Institute of Biomedical Research.

Election of Officers

In addition to Doctor Ward, the new president-elect, the following officers were named:

Dr. Carlton Wertz of Buffalo, vice-president; Dr. Milford O. Rouse of Dallas, speaker of the house, and Dr. Walter C. Bornemeier of Chicago, vice-speaker. Dr. Robert C. Long of Louisville was re-elected to the Board of Trustees for a three-year term, and Dr. Alvin J. Ingram of Memphis was elected to a three-year term. Doctor Ingram replaces Dr. R. B. Robins of Camden, Ark.

Nominated and elected to the Judicial Council was Dr. Charles C. Smeltzer of Knoxville, Tenn. Named to the Council on Medical Education were Dr. William P. Longmire of Los Angeles and Dr. William A. Sodeman of Philadelphia. Elected to the Council on Medical Service was Dr. John Rumsey of San Diego, and re-elected was Dr. Willard A. Wright of Williston, N.D.

Dr. William A. Hyland of Grand Rapids, Mich. was re-elected to the Council on Constitution and Bylaws.

HAROLD C. OCHSNER, M.D.
E. S. JONES, M.D.
FRANCIS L. LAND, M.D.
GUY A. OWSLEY, M.D.
JACK E. SHIELDS, M.D.

Reports of Committees

Executive Committee

As this report is prepared for presentation, we approach the conclusion of the 115th year of operation of the Indiana State Medical Association.

The Executive Committee, as is the case with all other bodies of the association, has been called upon to intensify its activity in the interests of association affairs.

The committee does not intend to present a lengthy, detailed report, as the minutes of the Executive Committee meetings have been published in *The Journal.* In addition, the minutes of the various meetings are available to the Reference Committee for review.

The Executive Committee has met each month since the close of the 1963 session, holding its first meeting on October 17, 1963, at which time, by secret ballot, Dr. Ralph V. Everly, Indianapolis, was elected chairman and Dr. George Willison, Evansville, was welcomed as a new member of the committee.

The committee then met on December 1st, at which time the delegates and alternate delegates to the AMA joined the members in a discussion of matters to come before the AMA Clinical Meeting and procedural methods to be used by the Indiana group. At this time, the president of the association was named chairman of the Indiana delegation and Dr. E. S. Jones was named floor leader of the delegates. As has been the custom the last three or four years, the delegates and alternate delegates, as well as members of the Executive Committee, were assigned definitive responsibilities to appear before the Reference Committees of the AMA to inform the committees of the views of the Indiana State Medical Association and to bring back to the group the results of these discussions. During the AMA clinical sessions, the delegates and alternate delegates met with the Executive Committee each morning before the sessions to review the events of the preceding day and to make plans for the new day.

As will be noted from the reports, the Executive Committee has been called upon to review the routine and organizational matters of administration of the headquarters office which were presented for decision. As many of these questions as possible were referred to the Council for its action, many with recommendations made by the committee.

Your Executive Committee is of the opinion that the association has made substantial, forward progress during the past year, as can quickly be seen by review of the reports which have been submitted by the various association committees and commissions.

Student Loan

The Council, at its July meeting, received a report from the treasurer concerning the financial status of the association. We have been attempting to "crawl out" of the deficit situation which accrued during the past few years with the publication costs of *The Journal* constantly increasing and advertising income constantly decreasing. It has been necessary, therefore, for your committee to use funds which should have been held in reserve for the last quarter of the calendar year. It has also, on two occasions, been necessary to borrow money from the bank until such time as the dues for the new year are received. In doing this, it has been necessary for us to take from the current year's dues money to pay off the indebtedness of the previous year. We are hopeful, in time, that we can work out this dilemma.

As was discussed before the Council, and at the Council's request, we include this matter in our report, the Student Loan Committee is presenting two recommendations to this House:

(1) That $10,000 of the money now in the Student Loan Fund, which was created by an advancement of $40,000.00 from the General Fund of the association, be loaned back to the General Fund on an interest free basis, to be repaid January 1, 1965;

(2) The committee also recommends that that portion of dues allocated by the House for student loan purposes to the Guaranteed Loan Fund, which was established through the Indiana National Bank, be diverted to the General Fund until such time as additional monies are needed in this guaranteed account. At the present time monies in the Guaranteed Loan Fund are sufficient to guarantee loans of some $260,000 and it is felt that this amount will suffice for the time being. The Executive Committee hopes that the House will see fit to concur with these recommendations to help alleviate our financial situation.

Medical Defense Activities

1. *Malpractice cases.* A year ago, at the time of this report, August 1, 1963, no cases were pending before the committee.

Since August 1, 1963, the following case was filed and is pending at this time:

Case No. 307 — Suit filed March 22, 1962. Pending.

2. *Medical Defense Fund Statement from August 1, 1963 to August 1, 1964:*

Cash in Bank, August 1, 1963		$3,159.94
Receipts:		
Dues	$4,945.85	
Interest	1,257.55	
		6,203.40
Total Receipts		$9,363.34

Disbursements:

Reimbursement for travel	$ 36.82
Attorneys' Retainer	2,790.00
Investment (Bonds)	3,986.20
Total Disbursements	6,813.02
Balance on hand, August 1, 1964	$2,550.32

Membership Report

	Dec. 31, 1963	July 31, 1963	July 31, 1964	AMA, 1964
1st District				
Gibson	16	16	15	15
Perry	12	12	11	11
Pike	4	4	4	4
Posey	10	10	10	10
Spencer	5	5	4	3
Vanderburgh	239	237	233	229
Warrick	9	9	7	8
TOTAL	295	293	284	280
2nd District				
Daviess-Martin	20	20	19	18
Greene	16	16	16	9
Knox	41	41	39	37
Owen-Monroe	62	62	61	59
Sullivan	15	15	15	13
TOTAL	154	154	150	136
3rd District				
Clark	38	38	41	40
Dubois	23	23	24	21
Floyd	38	38	37	36
Harrison-Crawford	11	11	12	12
Lawrence	24	24	23	21
Orange	9	9	9	9
Scott	4	4	4	3
Washington	8	8	7	7
TOTAL	155	155	157	149
4th District				
Bartholomew-Brown	43	43	43	42
Dearborn-Ohio	22	22	20	19
Decatur	12	12	12	10
Jackson-Jennings	25	25	25	22
Jefferson-Switzerland	25	25	29	25
Ripley	11	11	8	7
TOTAL	138	138	137	125
5th District				
Clay	13	13	12	12
Parke-Vermillion	26	26	25	25
Putnam	16	16	15	15
Vigo	118	116	117	117
TOTAL	173	171	169	169
6th District				
Fayette-Franklin	18	18	17	17
Hancock	20	20	20	20
Henry	42	42	40	40
Rush	15	15	15	15
Shelby	19	19	19	19
Wayne-Union	71	71	73	68
TOTAL	185	185	184	179

	Dec. 31, 1963	July 31, 1963	July 31, 1964	AMA, 1964
7th District				
Hendricks	22	22	23	23
Johnson	32	32	29	29
Marion	1067	1051	1059	1055
Morgan	17	17	17	17
TOTAL	1138	1122	1128	1124
8th District				
Delaware-Blackford	115	115	112	108
Jay	17	17	16	14
Madison	100	99	96	92
Randolph	22	22	21	19
TOTAL	254	253	245	233
9th District				
Benton	9	9	9	9
Boone	18	18	19	19
Clinton	20	20	18	18
Fountain-Warren	15	15	15	15
Hamilton	26	26	25	18
Montgomery	27	27	27	27
Tippecanoe	114	113	116	116
Tipton	11	11	11	11
White	11	11	12	12
TOTAL	251	250	252	245
10th District				
Jasper	7	7	7	7
Lake	426	415	411	388
Newton	5	5	5	5
Porter	33	33	32	32
TOTAL	471	460	455	432
11th District				
Carroll	9	9	9	9
Cass	39	39	38	38
Grant	68	68	71	71
Howard	64	64	67	67
Huntington	23	23	22	21
Miami	13	13	14	14
Wabash	25	25	25	24
TOTAL	241	241	246	244
12th District				
Adams	13	13	14	14
Allen	281	276	287	281
DeKalb	20	20	20	20
LaGrange	10	10	8	8
Noble	16	16	16	16
Steuben	13	13	13	13
Wells	33	33	37	37
Whitley	19	19	18	18
TOTAL	405	400	413	407
13th District				
Elkhart	109	108	108	106
Fulton	11	11	12	11
Kosciusko	17	17	19	18
LaPorte	98	98	101	99
Marshall	26	26	26	26
Pulaski	6	6	6	3
St. Joseph	237	236	233	233
Starke	6	6	6	6
TOTAL	510	508	511	502

SUMMARY

1st District	295	293	284	280
2nd District	154	154	150	136
3rd District	155	155	157	149
4th District	138	138	137	125
5th District	173	171	169	169
6th District	185	185	184	179
7th District	1138	1122	1128	1124
8th District	254	253	245	233
9th District	251	250	252	245
10th District	471	460	455	432
11th District	241	241	246	244
12th District	405	400	413	407
13th District	510	508	511	502
TOTAL	4371	4339	4331	4225

The Journal

Advertising

The Journal has continued to require much of the Executive Committee's attention during the past year, due to the financial situation caused by loss of advertising income. However, as will be noted by the report of the editor, *The Journal* has, since January, been published by another printer at less cost. Many other economy measures have been taken in *The Journal* and these, coupled with the increase in dues allocated to the support of *The Journal*, plus a slight increase in advertising income, have lessened the economic problems of the publication.

We are hopeful that the coming months will see continued improvement in the economic situation of *The Journal*.

This is a comparative report for the first six months of each year indicated.

	1961	1962	1963	1964
State Journal Advertising Bureau	$23,697.85	$21,538.08	$16,782.08	$13,474.13
Sold Direct by Journal	1,976.08	2,013.00	1,950.60	2,017.10
Total	$25,673.93	$23,551.08	$18,732.68	$15,491.23

Printing Costs

Year	Cost	No. of Pages (Inserts excluded)
1960	$62,679.13	2222
1961	49,539.57	1868
1962	51,291.51	1862
1963	44,212.23	1612
1964 (6 months)	17,534.90	708

Year	Reading	% Reading	Adv. Pages	% Adv. Pages	Total Pages	Av. Pages per Issue
1958	1055	52	969	48	2024	169
1959	1226	53	1088	47	2314	193
1960	1413	61	919	39	2332	194
1961	1284	67	634	33	1918	160
1962	1308	68	604	32	1912	159
1963	1139	70	487	30	1626	135

RALPH V. EVERLY, M.D., *Chairman*
G. O. LARSON, M.D.
DON E. WOOD, M.D.
JOE M. BLACK, M.D.
K. O. NEUMANN, M.D.
IRVIN W. WILKENS, M.D.

Grievance

The Grievance Committee held meetings on September 29, 1963, January 26, and June 7, 1964.

As of July 1, 1963, 27 cases had been considered by the Grievance Committee during the preceding twelve months. Of the 11 cases referred to the physician named in the complaints, nine were settled to the satisfaction of the complainant and two remained unsettled. Twelve other cases required referral to the county medical societies of jurisdiction, eight have been closed and four are pending. The ISMA Grievance Committee was thus required to assume adjudication efforts in the four remaining cases, two of which were closed with two yet unsettled.

Cases reported to the ISMA Grievance Committee have, during the past five years, been handled by the following procedure: (1) The request of permission from the complainant to forward a full copy of the complaint to the physician or physicians named. Failure to give permission terminates consideration of the complaint and the complainant is so informed. (2) If permission is received, the physician named received a copy of the complaint along with a suggestion that he attempt to settle the matter with the complaining party. (3) Should the physician not be successful or decline to act we ask that the issues involved be considered by the county society and (4) only when the county society declines adjudication, is unable to resolve the problem or when a state-wide issue is raised does the ISMA Grievance Committee proceed. In exceptional cases the physician involved may ask that the ISMA Grievance Committee attempt to resolve the matter rather than proceeding at the county level.

We wish again to remind all county medical society secretaries of the action of the 1962 ISMA House of Delegates which directs that a report be promptly sent to the ISMA Grievance Committee of any disciplinary action taken at the county level.

The attention of all ISMA members is directed to the 1963 action of the House of Delegates which makes reportable to the county medical society grievance committee for its action the collaboration of a ISMA member with any person who engages in the illegal practice of medicine. Under Section 8 of the Indiana Medical Practice Act this includes those persons who attempt to diagnose or treat diseases of the mind. This is interpreted to mean those conditions listed in the "Standard Nomenclature of Diseases and Operations, Diseases of the Psychobiologic Unit," or listed in the International Statistical Classification. Thus attempts to diagnose or treat emotional or mental illness by any technique be it called counselling, psychotherapy or whatever can ethically be carried forward only by a licensed physician or under his direct supervision. ISMA members are importuned

to avoid giving support to unlicensed persons who fail to secure or to maintain adequate medical supervision of their work with the emotionally ill or mentally ill as well as with the physically ill.

The Grievance Committee thanks ISMA members who as individuals or committee members responded promptly to the requests we were required to make during the past year in discharging our assigned responsibility.

PHILIP B. REED, M.D., *Chairman*
MARVIN L. McCLAIN, M.D., *Vice-Chairman*
PAUL L. STIER, M.D., *Secretary*
RAYMOND E. NELSON, M.D.
EARL W. MERICLE, M.D.
GUY A. OWSLEY, M.D.
H. ALLISON MILLER, M.D.
WILLIAM R. CLARK, M.D.
MAURICE E. GLOCK, M.D.
WILLIAM H. NORMAN, M.D.

Student Loan

For the past year, your Student Loan Committee has been operating two separate loan accounts; one, the continuation of the loan plan which was approved by the House of Delegates in 1955 and the other instituted by the House of Delegates in October of 1963. This report by necessity, will be given in three parts—the first part covering the original loan plan; the second section the new loan plan and the third part, the recommendations of the committee.

The House, in October 1955, instituted a loan program whereby it transferred a total of $40,000.00 from the general fund to be used as a revolving loan fund. From that date until July of 1963, 142 loans were made to 117 students. Total loans amounted to $58,458.36. Ninety-three students received one loan each; 23 students received two loans each, and one student received three loans. As of July 31, 1964, of the 117 students who have been assisted by this plan, 48 have repaid their loans in full, enabling the committee to grant additional loans over and above the original $40,000.00 earmarked for this purpose. Twenty-two students have made partial payments.

The financial status of the Student Loan Fund for ten months of the fiscal year 1963-64 is shown by the following report.

Cash on hand, October 1, 1963		$ 1,924.77
Receipts:		
Repayments on loans, 10/1/63 thru 7/31/64	11,433.74	
Interest earned on loans	450.39	
Donations	35.00	
Total Receipts		$13,843.90
Expenditures:		
Security deposit with Indiana National Bank	2,000.00	
Printing	281.01	
Refund—overpayment on principal on note..	60.39	
Total Expenditures	2,341.40	
Cash on hand as of July 31, 1964		$11,502.50

STUDENT LOAN FUND UNDER ASSOCIATION MANAGEMENT, October 1955 thru July 31, 1963

Total loaned to 117 students		$58,458.36
Total repaid in full by 48 loanees	25,058.36*	
Total partial payments by 22 loanees	5,867.26	
TOTAL AMOUNT REPAID	30,925.62	
TOTAL AMOUNT OUTSTANDING		$27,532.74

* Interest received on above 48 loans paid in full	$ 787.25
Interest on one loan (loanee granted extension of time for repayment of principal)	90.00
47 not yet paying on loans	

GUARANTEED LOAN PLAN

Since the last meeting of the House of Delegates, as directed by the House, the Student Loan Committee has with the approval of the Council consummated an agreement with the Indiana National Bank whereby the bank now makes loans to students under a guaranteed loan plan. Under the plan which became effective December 1, 1963, your Student Loan Committee receives applications from students seeking loans, reviews them and then either approves the application for a loan by the bank or disapproves the application. The student then arranges with the bank for the loan, giving security to the bank. Therefore the accounting of the outstanding loans and the collection is done by the bank rather than the association. Under this arrangement, the bank loans twelve and one-half dollars for every dollar placed in the guaranteed fund by the association. The monies placed in this guaranteed fund by the association are deposited in securities by the bank with the association benefitting from the interest thereon.

The rules and regulations established by the Student Loan Committee under which loans will be made through this plan are as follows:

1. Only citizens of the United States domiciled in Indiana and enrolled full-time in the Indiana University School of Medicine are eligible to apply for a loan, providing they have completed one full year in medical school.
2. Loans will not be made to students doing specialty work.
3. Loans will not be granted in excess of $1,000.00 per year. Loans can be had in multiples of $100.00.
4. Applications approved and endorsed by ISMA will be forwarded to the Indiana National Bank of Indianapolis and the bank will make the actual loan.
5. Loans made during matriculation in medical school will be on the basis of interim notes which will become due and payable fifteen (15) days prior to graduation from medical school at which time a payout note may be given.
6. Interest charged on interim notes will be based on the prime interest rate in effect at the time a loan is made plus one percent.
7. Fifteen (15) days prior to graduation interim notes will be accumulated into a payable pay-

out note, the first payment on which will become due the first day of the seventh month following completion of internship. Interest on payout notes will be calculated on the basis of the prime interest rate in effect at the time, less one percent, plus a small insurance charge.

8. Loans may be repaid in one lump sum or in monthly installments of not less than $30.00 per month, over a period not to exceed three (3) years.

To Make Application

9. (a) Complete this form in detail, answering fully all questions.
 (b) Answers may be typed, handprinted, or in script, and must be clearly and easily legible; and
 (c) References given must be to people who are sufficiently acquainted with the applicant to give reliable information in answer to questions regarding applicant's
 (1) Financial condition,
 (2) Physical and mental ability to complete adequate preparation for the practice of medicine and to carry on medical activity after preparation, and,
 (3) Conscientious sense of obligation to repay any loan made to him in accordance with its terms and dependability for payment of debts.
10. Applicant must be willing (a) to supplement the information given in the application form with any further information the committee may request, and (b) to make it possible for the committee to obtain satisfactory data through which it may verify any of the information given.
11. Applicant must, upon request, give the committee an authenticated report of his grades in the subjects he has studied in his premedical college and in his medical school work.
12. No loan will be made until the sophomore year except in very unusual and exceptional cases.

Since this new plan has been placed into operation, 16 applicants have been approved for loans by the committee for a total of $9,600.00.

Recommendations

Your Student Loan Committee has noted the House of Delegates provided that $5.00 of the members' dues should be placed in the guaranteed student loan account. Also, it notes that the House provided for all monies received from repayment of loans made under the original loan plan, to be transferred to the student loan guaranteed fund. As of this time, $2,000.00 of the original student loan account has been placed in the guaranteed loan fund and $18,810.00 of membership dues have been placed in this same account, making a total on deposit in this guaranteed fund of $20,810.00. As stated before, this money is placed in interest bearing securities with the association benefiting by the interest income. The present guaranteed account is sufficient to permit loans totaling $260,125.00 Inasmuch as the association has been called upon to provide only $9,600.00 in loans, during the past nine months, we feel the following recommendations warrant the approval of the House:

(1) BE IT RESOLVED, that the Student Loan Committee authorize the loan of $10,000.00 from cash on hand to the General Fund of the Indiana State Medical Association, without interest, to be repaid January 1, 1965.

(2) WHEREAS, this committee has on deposit with the Indiana National Bank $20,810.00 to guarantee loans to students under the new program and will receive repayment of the $10,000.00 loan from the General Fund January 1, 1965.

That in addition there are approximately $29,000.00 of accounts receivable in the form of outstanding loans made under the old program which can be added to the guaranteed fund which will make it sufficient to guarantee over one-half million dollars in loans, and

WHEREAS, there have only been 14 loans totaling $8,300.00 guaranteed loans made under the new program and an additional $1,300.00 in process,

WHEREAS, it appears that the $5.00 which will be received from the 1964 dues will not be needed for the guaranteed fund this year,

NOW, THEREFORE, BE IT RESOLVED, that the $5.00 from the 1964 dues for the Student Loan fund and this portion in the future be deposited in the General Fund until such time as the fund needs additional guarantee monies.

LESTER D. BIBLER, M.D., *Chairman*
JAMES O. RITCHEY, M.D.
DON E. WOOD, M.D.
IRVIN W. WILKENS, M.D.
JOHN I. NURNBERGER, M.D.
K. O. NEUMANN, M.D.
ROBERT HOLLOWELL, *Attorney*

Reports of Commissions

Constitution and Bylaws

The Commission on Constitution and Bylaws, having held several meetings during the year, recommends the following changes in the Bylaws of the Indiana State Medical Association.

Bylaws

(1). BE IT RESOLVED, That Section 7, Chapter IV, of the Bylaws be amended as follows: delete the second paragraph of said Section, which reads as follows: "Provided, that this sub-section of the Bylaws may be suspended with respect to any resolution upon a two-thirds majority vote of the House of Delegates." and substitute in lieu thereof the following: "Provided, that where a resolution has been first submitted to the Committee on Rules and Order of Business, with one hundred and fifty copies thereof, together with a written statement setting forth the reasons why said resolution was not mailed to the Executive Secretary so that he would receive it not later than forty-five days prior to the meeting of the House of Delegates and also setting forth in said written statement the reason why said resolution is of such emergency nature that it cannot wait until the next meeting of the House and said Committee on Rules and Order of Business has approved said resolution for submission to the House, then this sub-section of the Bylaws may be suspended with respect to said resolution upon a two-thirds vote of the House of Delegates."

(2). BE IT RESOLVED, That Section 5, Chapter IV, of the Bylaws be amended by inserting after the word, "the" and before the word, "Council", the words, "Executive Committee and" and by deleting from said Section the word, "its" immediately preceding the word "recommendation" and substituting in lieu thereof the word "their". The reason for this amendment is that under Section 2 of Chapter IX of the Bylaws, "the duty of preparing a budget is vested in the Executive Committee", and, therefore, any appropriate proposal to be made by the House should be submitted to the Executive Committee in order that it might consider its effect upon the total budget of the Association before final action thereon is taken by the House of Delegates.

The following proposed amendments to the Bylaws are to be submitted only in the event the amendments to the Constitution relative to an "Assistant Treasurer" shall be adopted:

(3). BE IT RESOLVED, That Section 4, Chapter V be deleted and there be substituted in lieu thereof:

"Section 4. The President, President-elect, Treasurer and Assistant Treasurer shall serve from the termination of the annual meeting of the House of Delegates in which the President-elect, Treasurer and the Assistant Treasurer are elected until the termination of the succeeding annual meeting of the House of Delegates."

(The reason for this proposed amendment is to conform such Section to the amendment to the Constitution, adding Assistant Treasurer).

(4). BE IT RESOLVED, that Section 3 of Chapter VI of the Bylaws be amended by adding as an additional grammatical paragraph thereto the following: "The Assistant Treasurer shall give bond at the expense of the Association in such amount as shall be required by the Council unless he is included in the coverage of a blanket or position bond. In case of death, or incapacity of the Treasurer he shall succeed to all the duties and rights of the Treasurer until the next meeting of the House of Delegates. In the absence of the Treasurer he shall attend to the duties and rights of the Treasurer during such absence and he shall also perform such duties of the Treasurer as may be delegated and assigned to him by the Treasurer.

G. O. LARSON, M.D., *Chairman*
B. D. WAGONER, M.D.
WILLIAM B. CHALLMAN, M.D.
JAMES N. TOPOLGUS, M.D.
THOMAS H. GOOTEE, M.D.
GORDON S. FESSLER, M.D.
A. W. CAVINS, M.D.
HOWARD E. SWEET, M.D.
JOSEPH F. FERRARA, M.D.
WILLIAM M. SHOLTY, M.D.
JACK E. DITTMER, M.D.
RICHARD L. GLENDENING, M.D.
HAROLD NUGEN, M.D.
JOHN B. CLEVELAND, M.D.
BURTON KINTNER, M.D.

Legislation

Being an off year for the Indiana State Legislature, your Commission on Legislation didn't meet as frequently.

The initial meeting following the annual convention was occupied with election, budget and concern over making the Kerr-Mills function in Indiana—getting ready for the primaries and supporting "Operation Hometown."

At the next meeting, November 24th, the individual physicians were urged to meet with their national representatives during the holidays—this was done in many areas with great success.

The third meeting was a joint affair sponsored by your commission. Guests were officers of component societies, officials of the Auxiliary, councilors, etc., and the commissions and committees of the Indiana State Medical Association.

At this meeting also were Dr. Don Wood, President of the Indiana State Medical Association; Mrs. Frank Gastineau; AMPAC Board members; Mr. Richard Cardwell, General Counsel of Hoosier State Press Association and Frank Woolley, our District Representative from the AMA.

The meeting was highly successful and will be planned again for the future.

An excellent film, "The Gift of Health" sponsored by the AMA, was also shown. This has been made available to all county societies for public

use and showing.

As you all know, the Supreme Court of the state validated the Kerr-Mills Bill (S.B. 132) in February, 1964, despite the Governor's veto. It has now been published as law in Indiana. The real problem, of course, is its implementation under the current administration.

Members of this commission attended the AMA Legal Conference for Medical Society Representatives held April 16-18, 1964; this took place in Chicago and was an exceptional meeting—three fine speakers worthy of note were Dr. E. B. Howard, of the AMA, George Hall, also of the AMA and Mr. Robert Murphy, Chief Legal Counsel for the Wisconsin State Medical Association.

Indiana State Medical Association officials, along with members of this commission, in the latter part of April made their annual visit to our congressmen and senators. This is a most exciting and worthwhile adventure that is well worth the time and expense.

Ideas and thoughts reviewed by and from these various meetings were incorporated into the June 7th meeting of your commission. Interest centered on legislative matters of concern to our society that should be considered in the future for the general good of organized medicine.

Of such concern were:

a). Privileged information;
b). Blood service laws;
c). Abused child legislation;
d). Therapeutic abortion legislation;
e). Kerr-Mills implementation;
f). Chiropractors being authorized to sue for injured federal employees under Workmens' Compensation S1710 and 52078.
g). Podiatrists being compensated under the Kerr-Mills Law.
h). Doctor shortage in Indiana and this problem with relationship to licensure in Indiana.
i). Only practicing physicians being coroners.

The commission has taken definite stands on some issues and will initiate action on others. Legal counsel is needed on some issues and others are being studied further by special committees.

These are some of the major issues for the House of Delegates in the State Meeting in October.

The commission wishes to thank all headquarters personnel for their excellent help and counsel throughout the year; this gratitude also applies to our legal counsel for its generous guidance.

As Chairman, I want to extend my personal thanks to every member of this commission for his dedication to duty and excellence of performance.

The future of medicine will be fought out in the political arena whether we like it or not—that is why this commission is so vital.

EUGENE F. SENSENY, M.D., *Chairman*
DWIGHT W. SCHUSTER, M.D., *Vice-Chairman*
JACK W. HICKMAN, M.D., *Secretary*
DANIEL M. HARE, M.D.
HAROLD MANIFOLD, M.D.
DON KERR, M.D.
LESLIE M. BAKER, M.D.
JOSEPH G. S. WEBER, M.D.
JAMES L. GARRISON, M.D.
PAUL T. LAMEY, M.D.
JAMES CRAIN, M.D.
PHILIP ROSENBLOOM, M.D.
DONALD K. WINTER, M.D.
OTIS R. BOWEN, M.D.
JOE M. BLACK, M.D.

Public Information

The commission met several times during the year to discuss a number of topics dealing with Public Information. In due course of the year the following matters were brought to their attention:

1. *Debate Kit Distribution*—Notices were sent by the commission to all high school superintendents in Indiana informing them of the availability of the debate kit information which included an introductory letter from Dr. Annis, President of the AMA; two booklets entitled, *"Federalized Health Care for the Aged, A Critical Symposium"* and *"Financing Medical Care, An Appraisal of Foreign Programs"* and the AMA brochure entitled *"Vital Questions and Answers on Health Care of the Aged."* As a result of this first mailing approximately 150 requests were filled. The commission then directed the headquarters office to mail the debate kits to the approximately 700 high schools in the state, which has resulted in continuing requests through the headquarters office.

2. *Television Series on "Doctors at Work"*—The commission made an extensive review of this series of television shows which could be adapted to programming by component county medical societies, who might desire sponsoring and participating in such shows as an excellent public relations and public information device. A survey was made of county medical societies and a return of 20% affirmative response indicated a definite desire to utilize these television programs as a series. The commission feels strongly that such programs enhance the public image of the individual physician and constitute an excellent method of informing the public of health problems and solutions. The commission, however, is still attempting to acquire funds to put such a series on the air. It is the hope of the commission that over the forthcoming year definite strides can be made in accomplishing this.

3. *Medical Society Fiscal Change*—The commission suggests that county medical societies continue to implement the recommendation that new officials of each society take office each year during the same time, when state officers assume their responsibilities. This period is always at the time of the annual meeting, either in September or October.

4. *County Medical Society Officers Conference*—The commission made tentative plans to hold the

County Society Officers' Conference but decided against holding one during 1964 in view of the February 2 Legislative Conference which was attended by representatives of most of the county medical societies in the state. However, the commission feels that the officers conference should be continued from year to year, since these meetings are beneficial to all who attend.

5. *Medical Self-Help Television Series*—The commission previewed and discussed, at length, the possibility of instituting a series of television films for the purpose of training the public in medical self-help for times of national disaster. The program is to be based on the AMA approved program. At the time of the writing of this report, plans were underway to put this series into effect sometime in the fall of 1964 through the cooperative effort of this commission, the Commission on Governmental Medical Services and the Indiana State Board of Health. Based on the experience of the Illinois State Medical Society's program, the commission hopes to enroll 10 to 20,000 Hoosiers in the course.

6. *Medical Journalism Awards*—All communication media in the state of Indiana were advised of the availability of these AMA awards by the commission. A covering letter and a brochure on the awards were included in the mailing.

7. *Special Story on Crash-Injury Research Program*—As a part of the public information program of the Indiana State Medical Association, a special story was released to *The Indianapolis Star* magazine on the new crash injury research program being participated in by ISMA, Cornell University, the Indiana State Board of Health, the Indiana State Police Department and the Indiana Hospital Association. The story appeared in the April 26 issue of the publication reaching approximately 350,000 Hoosiers. The story emphasized the role which ISMA has fulfilled in encouraging such research and told of the recognition of Elmer C. Paul, former lieutenant of the Indiana State Police, by the AMA and the ISMA. Paul is credited with initiating such research in Indiana and the nation. He was awarded a special citation in Washington, D.C. on April 27.

8. *Special Story on Emergency Medical Identification Symbol*—Again working in cooperation with *The Indianapolis Star* magazine, the Indiana State Medical Association disseminated vital information to the public on the universal emergency medical identification program as approved by the AMA. As a result of the story which was written by Mr. Joe Shepard and appeared on Sunday, June 7, the Indiana State Medical Association has provided, as of July 1, 406 of the identification cards and information on locations for procuring the emblem. This number does not include the many personal calls and telephone calls which were made to the headquarters office for this same information.

9. *Cooperation of Media*—The Public Information Commission wishes to make special recognition of the story in *The Indianapolis Star* by Harrison Ullmann, based on the pamphlet "8 Ways to Cut Doctor Bills" and the fine cooperation of all media —radio, television and newspapers—during the past year and during last year's convention in disseminating facts and details of the convention and its proceedings.

10. *Indiana Medical Journalism Awards*—The commission approved the establishment of such awards and adopted the following criteria for application and judgment of entries.

Each year throughout Indiana, newspapers, radio and television lend their support to the medical profession in many ways, including support of specific programs endorsed or initiated and conducted by the Indiana State Medical Association.

Usually this support goes unrecognized. Other organizations throughout the country, including the American Medical Association, have found awards programs both worthwhile and deeply appreciated by the recipients of such awards. And most of these organizations have found that such awards have enhanced their public relations with the various sections of the communications media, when they are given on the basis of sound criteria and judged critically and objectively.

With this brief preamble, the following recommendations are made concerning an annual ISMA awards program:

1. That one annual award be given in the state to a newspaper, radio and television station or an individual from each of these media who, in the opinion of the judges, merits such an award.

2. That the award be either a cash award and/or a suitable plaque or trophy.

3. In the event there is no eligible recipient, the award will not be given in any single category. In other words, just because there is an award does not mean that the award necessarily must be given each year. There must be a meritorious recipient.

4. Judges for the award shall be the Public Information Commission of the Indiana State Medical Association and three consultants chosen from each of the media areas—television, radio and newspapers.

5. The award shall be given on a calendar year basis, with a deadline of March 1 of the year following the year of production or publication.

6. The award is to be presented at the annual convention of the Indiana State Medical Association.

7. Award applications should be presented through the local county medical society, with a signature endorsement from the secretary or president of the society. In the event there is no application forthcoming from a particular division of the media and the Public Information Commission feels that such individual or media in a particular community should be adjudged in any year's competition, the commission may contact the group directly and with the approval of the local county medical society, solicit an application from such individuals, station or newspaper.

8. An appropriate application form should be devised.

9. Entries will be judged on the basis of accuracy, significance, quality, public interest and impact.

10. The award will be given for information relayed to the general public and not for relaying medical knowledge to the medical profession and to allied professions.

11. Entries for newspaper and magazine articles must be submitted in triplicate, at least one copy of which must be a tear sheet, authenticating the date of publication and showing the material as it appeared when presented to the public.

12. Entries for radio and television awards must consist of three copies of the complete script and a 200-word summary of the script. Television entries must be accompanied by a 16 mm. film with sound. Radio entries must be accompanied by a transcription or an audio tape of the show.

13. An entrant may submit as many entries as he wishes, but only one award each year will be given in each division.

14. Radio and television films and tapes will be returned, if requested. Other entries will not be returned.

It is the hope of the commission that the first awards can be made at the Indiana State Medical Association Convention in 1965 for 1964 qualifiers.

It is also the hope of the commission that the new commission for 1965 will continue with the programs which have been initiated by it, and implement wherever possible their utilization by the component county medical societies.

HARRY G. BECKER, M.D., *Chairman*
RICHARD W. HOLDEMAN, M.D., *Vice-Chairman*
GLEN McCLURE, M.D., *Secretary*
R. L. KLEINDORFER, M.D.
JOHN K. SPEARS, M.D.
HARRY R. BAXTER, M.D.
STUART R. COMBS, M.D.
ROBERT D. SPINDLER, M.D.
HOWARD FAUST, M.D.
JAMES M. KIRTLEY, M.D.
THOMAS C. CHAEL, M.D.
R. M. HUMMEL, M.D.
FREDERIC L. SCHOEN, M.D.
T. D. ARMSTRONG, M.D.
OTTIS N. OLVEY, M.D.

Governmental Medical Services

The Commission on Governmental Medical Services was re-organized at a meeting on November 10, 1963. The officers elected were: Dr. Charles R. Alvey, Muncie, Chairman; Dr. William Cron, Warsaw, Vice-Chairman and Dr. Herman Echsner, Columbus, Secretary.

Sub-committees were appointed and the following report for the past year is given.

1. *Disaster Preparedness*

There has been, during the past year, increased interest in the Medical Education for National Defense or MEND program. Dr. John J. Mahoney, Associate Dean of the School of Medicine, Indiana University, is the MEND coordinator. More medical disaster concepts are being placed in medical school curricula starting with the sophomore year. More faculty members and residents are attending the MEND symposia as well as week-long courses. The emergency ward in Indianapolis General Hospital serves as training point in disaster medical care for students.

The Medical Self-Help Training Courses continue to attract many students. Colonel Bates, Indiana Civil Defense Director, recently stated that Indiana has been among the leaders in the nation in the number being graduated from this course. With the cooperation of the State Board of Health and the Public Information Commission of the Indiana State Medical Association, this course of study is being put on television this fall. This committee recommends that doctors in various counties see that this TV course is put into every high school of the state as a part of their public health education program.

The Indiana State Board of Health continues to play a vital part in medical disaster planning. They now have a man who will help various hospitals over the state in perfecting disaster plans and also help with exercises of these plans, if needed.

The Indiana State Board of Health has another man who works with pre-positioned 200-bed hospitals, checking them for shortages, proper storage, etc. As soon as more money is available, the supplies of these hospitals are to be brought up to a 30-day level. The latest concept in regard to 200-bed hospitals is to coordinate them with existing hospitals so that the staffing problem will be lessened.

Other functions of the Indiana State Board of Health in helping with disaster planning include increasing chlorination systems for water supplies over the state, encouraging the immunization program, etc.

This committee notes that great strides have been made in the last year or two in locating rooms in various buildings suitable for shelters and in marking and provisioning these spaces. We urge that more attention be turned now to the family type shelters as public shelters will not be practical for rural areas.

2. *Mental Health*

The first of this year, the governor appointed the Indiana Mental Health Planning Commission composed of representatives of all activities and agencies having any interest in mental health. The commission includes 37 professional organizations, five voluntary citizen's organizations and 15 state agencies.

The former Joint Steering Committee for Mental Health composed of representatives of the Indiana State Medical Association; the Indiana Neuropsychiatric Association; the Northern Indiana Psychiatric Society; the Indiana Association for Mental Health and the Indiana Association for Retarded Children was appointed as the profes-

sional advisory committee to the planning commission.

The purpose of the commission is to survey in depth the projected needs of the state during the next 10 years for psychiatrists; mental health clinics, including treatment centers; child guidance clinics; half-way houses; day and night facilities as well as facilities for the mentally retarded.

The final report of the commission is intended to present a survey of needs to care for the mentally ill and mentally retarded, and to make recommendations as to how these needs can be met by communities and regions. The utilization of Federal funds appropriated for building local and regional mental health clinics and hospitals, and facilities for the mentally retarded, will be considered in this planning as well as state and local financing.

To accomplish the survey, upon which the commission's final report will be based, 11 task forces and 12 regional committees are being, or have been, appointed. Doctors asked to serve on such committees, or to assist the task forces, should do so in order that sound planning from the medical standpoint will result.

The pilot study based in Marion County and 15 surrounding counties is well under way. Five other regions are organized and ready to start. The other six regions will be organized by the end of the year. Regional meetings were conducted by the Indiana State Medical Association throughout the state last fall to promote active participation of the profession in this planning.

The long-term plan of the State Department of Mental Health includes plans for construction of five facilities to provide psychiatric services for children in cities of some size throughout the state. Each hospital will be of not more than 60-bed size. The centers will also be available for examinations of children from surrounding counties. On May 18, 1964, the State Budget Committee met and agreed to allocate the $500,000 appropriated by the legislature for completion of the plans and construction of the first of these centers in Evansville. It is expected that bids will be out and construction begun before the end of the year. The Evansville State Psychiatric Treatment Center for Children will admit emotionally disturbed children between ages six and 12 years. This age limit will not prevail for out-patient services. No funds have been appropriated for the other four centers.

The Second National Congress on Mental Illness and Health to be held by the American Medical Association will meet in Chicago on November 5-7, 1964. Every county medical society in Indiana should send a delegate to this congress so that we may all keep informed and be ready to offer leadership in meeting mental health problems. The AMA designates mental health as the number one health problem in the country today.

3. *Veterans Medical Care*

During the past year, a new fee schedule was negotiated between the Veterans Administration and the Indiana State Medical Association. This was accomplished during several meetings between your commission and representatives of the Veterans Administration. Each procedure was discussed and fees negotiated. We did not get all of the increases we requested but the commission feels that a step has been taken in the right direction. It does not appear proper to your commission that in dealing with the various governmental departments, there should be such a wide variance in these schedules. We are attempting to get all fees in relationship to one another. The following is a portion of the new schedule compared with the old.

Procedure Number	Description	Current Fee	Approved Fee
0005	Complete general routine physical examination including routine urinalysis (chemical)	$10.00	$12.50
0020	Examination to determine need for aid and attendance, in home	8.50	10.00
0045	Home visit (day 8 a.m. to 7 p.m.)	5.00	7.50
0050	Home visit (night 7 p.m. to 8 a.m.)	10.00	12.50
0070	Office visit	4.00	5.00
0125	Examination of ears, nose and throat	5.00	10.00
0145	Examination by neurologist to determine diagnosis	15.00	20.00
0150	Examination by psychiatrist to determine diagnosis	15.00	20.00
0155	Examination by psychiatrist to determine diagnosis and/or to evaluate residual disability	15.00	20.00
0200	Dermatological: first visit or home visit	7.00	10.00
0210	Ear, nose and throat: First visit or home visit	7.00	10.00
0225	Ophthalmological: First visit or home visit	7.00	10.00
0235	Psychiatric treatment, one half-hour or less	7.50	10.00
0240	Psychiatric treatment, period longer than one half-hour	15.00	20.00
0245	Other comparable specialties not listed above: first visit or home visit	7.00	10.00

Your commission wishes to express its appreciation to the Veterans Administration staff for its understanding and also to take note of the loss to our community and association due to the death of Doctor McClung, Veterans Administration District Medical Director.

4. *Liaison with Veterans Affairs*

The liaison committee has met every three months with representatives of the Indiana State Medical Association, Indiana State Dental Association, Indiana State Hospital Association, Indiana State Pharmaceutical Association and the American Legion.

At the September, 1963 meeting, Dr. Joseph H. McNinch, Chief Medical Director of Veterans Administration was present and considerable discussion was held on the Veterans Administration

medical policy. A copy of his remarks will be found in your delegates material.

As you see, there is Congressional authorization for the establishment of nursing home type beds within various Veterans Administration hospitals. This is to be accomplished without an increase in total bed allowances according to the bill passed; however, it is difficult for your commission to see how this will be feasible with the increasing number of veterans who seem to be using Veterans Administration facilities.

It has been the opinion of the American Medical Association and of this association for many years that Veterans Administration facilities should be used for those with service-connected disabilities and for those with non-service connected disabilities who are really in need and unable to pay for the service, this concept should be re-emphasized.

This commission will continue activities with the liaison committee.

5. *Liaison With Department of Public Welfare*

There have been no problems on general welfare program brought to this commission. However, it is to be noted that the Governor's veto of the bill on Kerr-Mills implementation was ruled illegal and this program is now being studied and implementation is, we hope, coming. This aspect of our association activity was taken over with the appointment of Dr. John Paris to the advisory commission on Kerr-Mills to the Director of Public Welfare of the state of Indiana. We hope for a report from Dr. Paris on this program.

6. *Medicare*

The Medicare operation of this commission is now in the seventh year and continues to show a slight increase in utilization by dependents of the members of the armed forces.

The committee handled over 6,000 claims in the past year and payments to physicians amounted to $267,594.03 for the first seven months of 1964.

The Physicians Review Committee continues to review claims and authorize them for payment.

We are still having a little difficulty with the large percentage of claims which must be returned for additional information. The Medicare program is different than usual insurance programs with which physicians and their office staffs are familiar and, therefore, creates some problems in completing the detailed claim form which the government requires. The policy of this committee, in reviewing these claims, is to allow as nearly as possible the physicians' billed fee for services rendered so long as it is commensurate with the economic level of the patient which he has under treatment. Also, inasmuch as the payment formula is different from the insurance companies and Blue Shield, in order to adjudicate the claim properly and to allow as much of the physician's fee as possible, additional information many times is required. The committee is happy to report that it has been able to pay about 90% of all the claims in the full amount billed by the physician.

Physicians should remember that medicine is in control of the administration of this program, under the regulations prescribed by the Department of Defense. It is therefore to our interest as physicians, as well as your committee, to prove that such a program can be efficiently operated.

CHARLES R. ALVEY, M.D., *Chairman*
WILLIAM J. CRON, M.D., *Vice-chairman*
HERMAN ECHSNER, M.D., *Secretary*
WILLIAM C. FISHER, M.D.
CHARLES HENDRIX, M.D.
GENE S. PIERCE, M.D.
DICK J. STEELE, M.D.
GLEN WARD LEE, M.D.
EDWARD J. DIEROLF, M.D.
JEAN V. CARTER, M.D.
OKLA W. SICKS, M.D.
ERNEST C. MURRAY, M.D.
ARVINE POPPLEWELL, M.D.
RAMON B. DUBOIS, M.D.
GEORGE D. BUCKNER, M.D.

Public Health

During the year of 1963-1964, the Commission on Public Health has continued its activity in essentially the same fields as it has in previous years. The scope of activity seems to be extremely broad and there has been excellent participation by the membership and very good attendance at the formal meetings of the committees and the commission as a whole. The practice of calling doctors with special experience to work with the commission as ex-officio members has been continued and expanded and these ex-officio members are acknowledged in this report with gratitude for their participation.

About the same committee structure has been continued and seems to have served very satisfactorily.

One of the relatively new projects referred to the commission has been that of the broad subject of environmental medicine. A formal meeting, sponsored by the American Medical Association Committee on Environmental Medicine was held in Chicago and Dr. Emmett B. Lamb, Chairman of the Commission on Public Health, attended as a representative from the commission. This subject must be further considered as it applies to the local community and an effort must be made to coordinate public health efforts between different communities in the state where environment is rapidly changing, due especially to population concentration, pollution problems of air, water and soil and the handling of new chemical products such as paints, detergents, insecticides, weed sprays, food preservatives, etc. Planners in this field are accepting the concept that this environmental medicine must represent the total environment with all exposures, regardless of the activity or the location.

Standing committees have been maintained during the past year as follows:

Committee on Industrial Medical Practices and Programs

Lowell W. Painter, M.D., *Chairman*
Jacob Fleischer, M.D.
H. Glenn Gardiner, M.D.
Daniel Gard, M.D., *ex-officio*
E. S. Jones, M.D., *ex-officio*
James Taylor, M.D., *ex-officio*
William Baughn, M.D., *ex-officio*
Edmund B. Haggard, M.D., *ex-officio*

Committee for Preventive Medicine and Liaison with the State Board of Health

Gerald F. Kempf, M.D., *Chairman*
John P. Turner, M.D.
Berniece M. Williams, M.D.
Arnold W. Brockmole, M.D.
T. O. Middleton, M.D.
Louis Spolyar, M.D., *ex-officio*
Andrew C. Offutt, M.D., *ex-officio*
Ralph Wilmore, M.D., *ex-officio*

Committee on Rural Health and Physician Placement

Eugene S. Rifner, M.D., *Chairman*
Forrest J. Babb, M.D.
John B. Hickam, M.D.
John Davis, M.D.
R. M. Seibel, M.D.

Committee on Traffic Safety

Howard T. Hammel, M.D., *Chairman*
John P. Turner, M.D.

Report of Committee on Industrial Medical Practices and Programs

The Committee on Industrial Medical Practices and Programs has had several meetings during the past year and considerable effort and time has been spent on attempting to evaluate and gain information as to the present status of these "Industrial Medical Practices and Programs."

Some of the major efforts by this committee were spent in sending a questionnaire to a relatively large group of Indiana doctors thought to have an interest or some knowledge in this area. In addition to this questionaire, an announcement with a similar request for information or suggestions was published in *The Journal*. The response to both was most disappointing but the committee has considerable material gained from other sources which must be seriously considered and evaluated.

It seems that one of the great needs is to create an awareness on the part of Indiana physicians that they must have an interest in Industrial Medical Practices and Programs if they are to serve their patient with maximum efficiency, regardless of whether that patient is directly employed, self-employed or the dependent of one who so is.

The committee would like to emphasize to all doctors that it is the physician's responsibility to inquire as to occupational activity when treating a patient, and where a valid third party interest exists under the Workmens' Compensation Act, or thorough group, health and accident insurance, that interest must be respected. The importance of prompt, complete and accurate reporting must be stressed and efforts must continually be made toward coordination in medical evidence and cooperative communication between all doctors. This can be done; however, ethical standards and legal requirements of confidence must be respected.

Since the American Medical Association's Council on Occupational Health will co-sponsor the program of the Indiana State Medical Association in October, 1965, this committee recommends that closer liaison with the Council of Occupational Health and its programs, publications and recommendations should be established.

The committee will, in the near future, prepare for publication a preliminary report of an outline of procedures or suggestions. It is urgently suggested this program should be continued.

LOWELL W. PAINTER, M.D., *Chairman*

Report of Committee for Preventive Medicine and Liaison with the State Board of Health

The Committee for Preventive Medicine and Liaison with the State Board of Health has continued its efforts essentially along the same line as previous years. Numerous questions have been referred to it and apparently have been answered and reported through proper channels. Some of the important items during the past year were as follows:

In December, 1963, the Committee for Eradication of Tuberculosis completed its plan and submitted it to this commission and the Council of the Indiana State Medical Association. Copies of the plan were sent to each member of the Council and to each member of the commission. At the meeting on January 19, 1964, it was pointed out that this was largely an expansion of the original proposals passed by this commission and the Council in 1961. This was approved by the commission and later by the Council and has since been sent to all of the members of the Indiana State Medical Association.

The committee reviewed and reported on "Plans for Rehabilitation Services." It also reviewed a pamphlet on the Tine Test with the recommendation that tuberculin testing be done as a continuing program, as recommended in the plan for eradication of tuberculosis.

The committee reviewed the Resolution on cigarette smoking and recommended that the commission approve the reference committee's reports as adopted by the House of Delegates of the AMA at its June, 1964 session, which includes this Resolution.

The committee reviewed the Resolution on detergents and suggested that the commission approve the ideas set forth, but that since representatives of industry were working on this problem and ex-

pected to meet and solve it by 1965, no further action be taken by the commission. This was done after hearing a report by Dr. Spolyar at the meeting of the commission on July 12, 1964.

In conclusion, it seems that this committee should continue in about the same sphere of activity, possibly with increasing attention to the "total environment" to which individuals are exposed and consider closer liaison with the AMA Committee on Environmental Health.

GERALD F. KEMPF, M.D., *Chairman*

Report of the Committee on Rural Health and Physician Placement

This committee acted in the interests of rural health and physician placement again this year. The staff of the Indiana State Medical Association carried on physician placement in its usual manner. Each month *The Journal* carried a list of those communities who have recently requested a physician and those physicians who have recently requested a place to practice within the state of Indiana. Never are there enough physicians to go around! This constant need for physicians in rural areas is a problem which this committee has studied with the deepest of concern. For this reason, the Junior-Senior Day has been held for the past several years. Junior-Senior Day was held on Saturday, March 21, this year. Not only was this well announced through a personal appearance of the chairman of this committee before the juniors and seniors of the medical school, but many placards were placed strategically throughout the medical school concerning this activity. A newspaper announcement of this meeting was placed in the April 9, 1964, *Indianapolis Star* on the same page as an article on the Belgium doctor's strike. We felt that this put our state profession, in general, in a good light. Some two hundred and eighty-nine (289) students and their wives made reservations for this event. It was well received and many questions were asked of the panelists. The committee wishes to thank Mead Johnson Company and Blue Shield for helping sponsor this event. We feel that it was worthwhile and should be continued.

The chairman of this committee attended the Rural Health Conference in Hot Springs, Arkansas in the fall of 1963, and the Seventeenth National Conference on Rural Health in Columbus, Ohio on March 6, 1964. The chairman has contacted some of the farm groups concerning the tetanus program. So far, this has not been successful and must be followed more vigorously.

It is strongly felt that the National Conference on Rural Health should hear of Indiana's Junior-Senior Day. This report will also be forwarded to the AMA Headquarters Office.

The members of this committee feel that the future committee should continue the physician placement bureau through the headquarters office, should continue liaison with the farm and rural groups throughout the state and, finally, should continue the Junior-Senior Day, attempting to interest students in their formative years in the practice of rural medicine within the state of Indiana.

EUGENE S. RIFNER, M.D., *Chairman*

Report of Committee on Traffic Safety

The Committee on Traffic Safety, during the past year, has had few questions referred to it but has continued to keep liaison with voluntary and governmental groups concerned with traffic safety.

It is again recommended that closer liaison and membership in the Indiana Traffic Safety Foundation should be acquired by the Indiana State Medical Association.

There is to be a workshop on school and community health at Indiana University, Bloomington, in August, 1964. The Indiana State Medical Association is one of the co-sponsors. They will have Elmer C. Paul, chief of the Protecting Device Section, Traffic Safety Branch, Division of Accident Prevention of the Department of Health, Education and Welfare, as speaker. The Workshop will place special emphasis on traffic and driver safety.

The committee would suggest that this program be continued, with possibly further careful consideration being given to vehicle equipment and safety and driver licensing.

HOWARD T. HAMMEL, M.D., *Chairman*

In conclusion, it is recommended by the Commission on Public Health of the Indiana State Medical Association that the above described programs be continued in the coming year. For those projects which require public programs, longer range planning should be made in the way of meeting announcements and reservations, which, of course, must be tentative, depending upon the final decision of the new commission after the annual meeting.

It is recommended, however, that further consideration should be given either by this commission, or a special committee outside it, to work with and maintain liasion with the American Medical Association's Committee on Environmental Medicine.

EMMETT B. LAMB, M.D., *Chairman*

Voluntary Health Agencies

The first meeting of the commission was an organizational meeting on October 17, 1963, at which time Dr. Lucian A. Arata was elected secretary; Dr. James Gosman, vice-chairman and Dr. Norman R. Booher re-elected chairman.

There have been some changes in the personnel of the commission during the year but the commission as finally constituted is as follows:

(1st Distr.) James R. Mathews, 715 First Ave., Evansville

(2nd Distr.) Herbert O. Chattin, 729 Main St., Vincennes

(3rd Distr.) Kenneth H. Brown, 410 E. Spring St., New Albany

(4th Distr.) Robert Acher, 221 E. Washington St., Greensburg

(5th Distr.) Stuart R. Combs, 3050 Poplar St., Terre Haute

(6th Distr.) Lucian A. Arata, 327 W. Broadway, Shelbyville

(7th Distr.) Norman R. Booher, 447 E. 38th St., Indianapolis

(8th Distr.) Alton H. Ridgway, Lapel

(9th Distr.) Donald L. McKinney, Box 398, Otterbein

(10th Distr.) Walfred A. Nelson, 559 S. Lake St., Gary

(11th Distr.) Wendell W. Ayres, 500 Wabash Ave., Marion

(12th Distr.) Robert G. Taylor, 2902 Fairfield Ave., Fort Wayne

(13th Distr.) William F. Oren, 919 E. Jefferson Blvd., #301, South Bend

(At Large) James Gosman, 2901 N. Meridian St., Indianapolis

(At Large) Wendell A. Shullenberger, 1815 N. Capitol Ave., Indianapolis

(Consultant) Doris H. Merritt, 1100 W. Michigan St., Indianapolis

The first business meeting of the commission was held on February 2, 1964, and it was decided that the commission would function in a similar fashion as in the past and the following members were assigned as liaison representatives to the voluntary health agencies as listed below:

Liaison Representatives To Voluntary Health Agencies (1963-1964)

Tuberculosis—Herbert O. Chattin, M.D. and Robert Acher, M.D.

National Foundation—Wendell A. Shullenberger, M.D., James H. Gosman, M.D. and Stuart R. Combs, M.D.

Heart—James R. Mathews, M.D. and Kenneth H. Brown, M.D.

Mental Health—Robert Acher, M.D. and Lucian A. Arata, M.D.

Muscular Dystrophy—Wendell Ayres, M.D.

Diabetes—Kenneth H. Brown, M.D.

Cancer—Walfred A. Nelson, M.D., Donald L. McKinney, M.D. and Robert G. Taylor, M.D.

Crippled Children—James R. Mathews, M.D. and A. H. Ridgway, M.D.

Cystic Fibrosis—Kenneth H. Brown, M.D.

Multiple Sclerosis—A. H. Ridgway, M.D. and Donald L. McKinney, M.D.

Cerebral Palsy—Herbert O. Chattin, M.D. and Wendell Ayres, M.D.

Arthritis—William Oren, M.D. and Alton H. Ridgway, M.D.

Social Health Association—James R. Mathews, M.D.

Aiding Leukemia Stricken American Children—Herbert O. Chattin, M.D.

Ind. Assoc. for Retarded Children, Inc.—Wendell Ayres, M.D.

City of Hope—Walfred A. Nelson, M.D.

Indiana Epilepsy Society, Inc.—A. H. Ridgway, M.D. and Stuart R. Combs, M.D.

Myasthenia Gravis Foundation, Inc.—Wendell Ayres, M.D.

Sister Kenny Foundation—W. A. Nelson, M.D.

At the time of the last annual report of this commission, a special consideration was a Resolution submitted to the House of Delegates of the American Medical Association by the Indiana State Medical Association as reported in the supplemental report of this commission in 1963. In brief, this Resolution called upon the House of Delegates of the American Medical Association to mandate its Committee on Voluntary Health Agencies to act as an accrediting agency for all voluntary health agencies and disseminate facts about them to all doctors, and especially the constituent and component medical societies.

As a result of the Resolution submitted, the House of Delegates referred this matter to the Board of Trustees and the so-called Shipman Committee, or Committee on Voluntary Health Agencies of the American Medical Association. At the clinical convention in Portland in December, 1963, the action on this Resolution by the House of Delegates was failure to approve but it redefined the duties of the Committee on Voluntary Health Agencies of the American Medical Association and elevated the status of this group to that of a council. As a part of this review the constituent state societies were urged to continue their individual approaches to this problem. The specific agency under the greatest question, the National Foundation, has greatly clarified its purposes to the American public in soliciting funds. The National Foundation no longer advertises itself as "guardian of the nation's health" and has made it clear in its propaganda that it is dealing more with arthritis and birth defects than it is with poliomyelitis.

As a result of the work of Indiana's Commission on Voluntary Health Agencies, the chairman, Dr. Norman Booher, was elected by the AMA Board of Trustees as a member of the council of the same name of the American Medical Association.

A new set of policies, supplementing the policies laid down in "Handbook for Medical Societies and Individual Physicians on National Voluntary Health Agencies" has been issued in a brochure, called "Professional Relationships with Voluntary Health Agencies." This is a similar set of policies but does change the definition of a voluntary health agency. This policy booklet has been reviewed by this commission and is found workable. As a result of the expansion of the Council on Voluntary Health Agencies, a new handbook of this sort is being published in October, 1964.

Also, as a suggestion from the Indiana group, a National Conference on Voluntary Health Agencies will be held in Chicago on September 17-18, 1964, in which most of the members of this commission will participate.

The commission has held other meetings during the year, and as a result of its deliberations, it was decided on the advice of legal counsel, that rather than to "approve" or "disapprove" agencies that the terms "recognized" or "not recognized" would be used. A slight revision of the questionnaire for reporting of the agency was made for clarification.

At the meeting on May 17, 1964, it was the decision of the commission that only agencies that are operating on a state-wide basis should be considered by the commission of the state medical association and that agencies operating on a county basis should seek recognition from the county medical society. This was done as a result of the following motion which was passed: "It was moved that it shall be the policy of this commission to consider for recognition only those organizations operating on a state-wide basis—that any organization operating on a county basis only, shall seek recognition from their own county medical society, and that we stand ready to advise any county medical society with facts that are available to us, if requested by the county medical society."

At the May 17 meeting of the commission, representatives of all the agencies with whom the commission has dealt during the year were invited to a joint meeting at which time the program conducted by this commission was open for criticism. The members of the commission were pleased to hear that the Indiana State Medical Association was given a large measure of praise for its work in this field and the only suggestions received were those which would amplify the operation of the commission. No critical suggestions were made.

It was recognized by all that the matter of communications was the most serious problem remaining unsolved.

At the joint meeting of the agencies with the commission, Miss Barbara Farley, staff coordinator of the Council on Voluntary Health Agencies of the American Medical Association, audited the meeting and gave very favorable comments from the point of view of the national organization.

As a result of the deliberations of the commission, the following disposition of agencies during the year has been made. (Because of fiscal year dates some agencies recognized in 1963 have not yet been considered for 1964).

1. The Indiana Society for Crippled Children and Adults, Inc.—1963—recognized—1964—recognized—with one question asked concerning office expenses, which was answered.
2. The Indianapolis Diabetes Association—1963—recognized—1964—recognized.
3. Marion County Cancer Society, Inc.—1963—recognized—1964—(to be recognized by county medical society—see motion of May 17).
4. The Evansville Epilepsy League, Inc.—1963—recognized—1964—(changed to Indiana Epilepsy Society, Inc. Recognized with recommendation that they consolidate their activities with other epilepsy groups.)
5. The Arthritis and Rheumatism Foundation—1963—approved—1964—no questionnaire received.
6. Indiana Association for Retarded Children, Inc.—1963—recognized—1964—recognized.
7. Social Health Association of Indianapolis—1963—recognized—1964—recognized.
8. United Cerebral Palsy of Indiana, Inc.—1963—recognized—1964—recognized.
9. The American Cancer Society, Indiana Division—1963—recognized—1964—recognized.
10. Indiana Association for Mental Health—1963—recognized—1964—recognized.
11. Indiana Tuberculosis Association—1963—recognized—1964—recognized.
12. Indiana Heart Association, Inc.—1963—recognized—1964—recognized.
13. Myasthenia Gravis Foundation, Inc. (Indiana state chapter)—1963—recognized—1964—no questionnaire received.
14. Cancer Society of St. Joseph County—1963—recognized—1964—(to be recognized by county medical society—see motion of May 17).
15. National Multiple Sclerosis Society (Indiana chapter)—1963—recognized—1964—(questionnaire just received and sent to liaison representatives—6-15-64).
16. Indiana Society for Prevention of Blindness—1963—recognized—1964—no questionnaire received.
17. Muscular Dystrophy Foundation—1963—recognized—1964—recognized.
18. Allen County Cancer Society—1963—recognized—1964—(to be recognized by county medical society—see motion of May 17).
19. National Foundation—1964—qualified recognition—(qualification because they still have not recognized the stated policy of the AMA that physicians be members of the board of directors of National Voluntary Health Agencies).

The commission desires to express its appreciation to the staff of the headquarter's office, especially Mr. Kenneth Bush and Miss Eleanor Chapple, for the very extensive and cheerful cooperation during the year, and, as chairman, I would like to thank the members of the commission for the many hours of hard work that they put in in the interest of organized medicine.

NORMAN R. BOOHER, M.D., *Chairman*

Medical Economics and Insurance

The commission met on November 17, 1963, February 16, 1964, April 18, 1964 and June 14, 1964 with exceptionally good attendance at each meeting.

A few of our members were assigned subjects to be kept under surveillance during the year, but for the most part each problem this year was approached by the commission as a whole in as relaxed and open a manner as possible. Although this type of approach was more time consuming, it was equally more revealing and we learned to really know and understand each other.

The Executive Committee of the Indiana State Medical Association requested that we study a letter from the Health Insurance Council and the action taken by the House of Delegates in October of 1963 on County Medical Societies' Insurance Review Committees to determine whether or not

a misunderstanding existed and to detail our recommendations concerning the establishment of voluntary review mechanisms at the county society level and the depth to which these review committees would be charged with responsibility.

Our recommendations, as compiled by William H. Garner, Jr., M.D., were as follows:

The Commission on Medical Economics and Insurance has reviewed the recent letter referred to it concerning the establishment of a review board for use by the insurance companies to settle insurance disputes. The commission strongly recommends that the Indiana State Medical Association aid the county societies in establishing these review boards.

It has also been recognized that the insurance companies having a desire to utilize this service contact the county medical societies in which the review board should be present.

The Commission on Medical Economics and Insurance welcomes communications concerning the problems arising in this program and since adequate time has not elapsed since the institution of this service no conclusions can be made of its efficiency at this time.

The Commission on Medical Economics and Insurance, however, would like to recommend that at least the following procedure be established in the protocol of the review boards:

1. In matters to be presented to the review board the parties involved submit in writing the problems involved or questioned. That these complaints or disputes shall be available to all parties involved, that is, the physician, the insurance company, the insured and the review board.

2. That the board be open to review only insurance disputes, and that any party involved may initiate review by the board, the insurance company, the physician or the insured.

3. The findings of the board be recommendations only and not binding on the parties involved.

4. The dispute shall be first discussed by the parties involved and if no solution is found, then review by the board can be considered.

5. The Commission on Medical Economics and Insurance recognizes that one of the salient problems in disputes is a lack of understanding between the groups involved. It is recommended to the insurance company that simplified and understandable language be used in insurance contracts, so that the insured as well as the physician can read these contracts with full understanding of their context.

6. That both the commercial carriers and Blue Cross-Blue Shield can utilize the use of the review boards and that the review by the boards shall not be limited to any particular insurance group.

At this time it is not recommended that a statewide review board shall be established until such a need is demonstrated.

In anticipation of Blue Shield questions, Mr. Richard Kilborn of Blue Shield was invited to our February meeting. The following is a summary of his comments as well as observations and conclusions on Blue Shield made by various members throughout the year:

1. *Separation of surgical assistant fees from regular surgical indemnities.* Mr. Kilborn—Such a rider is now available, but has been purchased by only three accounts. The assistant's fee amounts to about 25% on the surgical fee. The General Motors contract has a provision for "technical surgical assistant," and this coverage will probably increase as other industries follow suit.

Dr. Leffel—Believes that this is important to prevent abuse of present means of dividing fees and because of increasing necessity for surgical assistants in accredited hospitals. Two claims should be filed: one for the surgeon and one for the assistant, and that this has been formally recommended by the House of Delegates.

Doctor Garner—This separate fee rider is hard to sell, and there is no unanimity of opinion as to what the assistant's fee should be.

2. *Separation of pre- and post-natal care and delivery fees.* Mr. Kilborn—The obstetrical fee is a straight indemnity for all contracts with a maximum of $100.00 and this can be distributed in any manner desired by the physicians involved in any particular case.

3. *Intensive care benefits.* Ten percent of contracts have this endorsement now, stimulated by the example of General Motors.

4. *Mental Health coverage.* Mr. Kilborn—A rider is now available to increase the number of days of medical service in the hospital. General Motors will probably have this for 365 days, plus an allowance for shock therapy. Some consideration has been given to a deductible feature. Most contracts now provide only 30 days coverage for in-hospital medical treatments.

We are grateful for the wisdom shown in the appointment of Dr. Hardtke and Dr. Van Den Bosch, psychiatrists, to this commission, because of increased interest in insurance coverage for psychiatric illness. A recommendation to us from the Indiana Neuropsychiatric Association for the addition of a psychiatrist to the Blue Shield Board has been considered by the Council and Dr. Neumann's letter to the secretary regarding this appointment of a psychiatrist has been forwarded to the Indiana Neuropsychiatric Association asking them to make a specific recommendation for the appointment.

5. Data was presented concerning Blue Shield incidence rates from 1958 through 1963, noting particularly the increased rate of the *diagnostic program.* Later, Dr. Barnhart listed diagnostic admissions along with the problem of pre-existing conditions as two areas of difficulty with Blue Cross-Blue Shield. He suggests that the local review committees could arbitrate these problems better than a Blue Cross Physicians Advisory Committee. In a general discussion, Blue Cross review of admissions by lay employees studying

copies of hospital order sheets was criticized.

Mr. James Waggener, Executive Secretary, brought to our attention certain criticism of the AMA Disability Income Plan, particularly the fact that it does not provide benefits until the full *waiting period of a year* has elapsed from the beginning of the sickness or disability from the accident. It was also noted that it has been more or less the policy of the ISMA neither to approve or disapprove any particular insurance program. After reviewing the history of the development of this policy and with the realization that (1) the AMA Disability Plan was designed primarily to supplement existing state programs and therefore, of necessity, would fall short in coverage since we had no plan in existence, (2) there can be certain economic advantages to group insurance plans as contrasted to private contracts and (3) it can be good public relations for the ISMA to offer an additional benefit of membership in the form of Insurance Plans (we have none); this commission has re-evaluated its position on this policy and through a motion made by Dr. Goodman and seconded by Dr. Beeler, recommended to the Council that the Indiana State Medical Association endeavor to develop a group disability program, primarily to cover the first year of disability, later plans to be developed if approved by the Council.

For those who might be interested, Dr. Thomas G. Hamilton, (Columbia City) has already acquired considerable information on disability insurance with plans requested from four companies, including one from Continental Casualty Company with ISMA's long-time friend, Thomas Hendricks, personally behind it.

Representatives of casualty insurance business (medical coverage — automobile and home owner accidents) have asked us for help in developing simplified and standardized casualty report forms. You may be assured that they will get all the help that they need on this one. The reason—it costs us to fill out complicated and varied forms—it costs them to review them. They can have a very simple form filled out by any grateful doctor for free, but if they want a complete history and physical they can be prepared to pay the going rate to get it.

Upon the suggestion of Dr. W. R. Van Den Bosch this commission recommends to the House of Delegates for direction of the Council, the establishment of a committee to study and devise a plan of action to be taken by the Indiana State Medical Association when and if the association or component societies are faced with a situation similar to that of our colleagues in Belgium, Sweden, Italy, Argentina, etc. where government or an insurance company takes undue measures that infringe upon the rights of free medicine and threaten good medical practice. He suggests that the basic principle in the association's plan should be the realization that no third party's restrictive mandates could exist very long without the doctors' cooperation in their paper work. It was also suggested that the "plan" anticipate retaliatory measures directed at physicians through economic pressures.

This suggestion might be more timely than most of us realize. It is doubtful that medicine in the U.S.A. can remain the only island of medical freedom in the world. What has been successfully accomplished by medicine in its fight against infringement has been proportionate to the unity of the doctors involved. Certainly *a* plan would be better than no plan at all and it is equally as certain that a plan conceived during a period of reasonable tranquility must be a better plan than a plan developed in desperation and haste during a period of emotional upheaval.

I wish to express my personal appreciation to the members of this Commission on Medical Economics and Insurance for their diligent work and interest and to Mr. James Waggener and his staff for their counseling and cooperation during a year that has been most interesting.

JACK W. HANNAH, M.D., *Chairman*
WILLIAM H. GARNER, JR., M.D., *Vice-Chairman*
CHESTER A. STAYTON, JR., M.D., *Secretary*
WILLARD T. BARNHART, M.D.
JOHN W. BEELER, M.D.
R. JAMES BILLS, M.D.
HUBERT T. GOODMAN, M.D.
THOMAS G. HAMILTON, M.D.
ELDRED F. HARDTKE, M.D.
JOSEPH L. LARMORE, M.D.
JAMES M. LEFFEL, M.D.
WILLIAM SCHARBROUGH, M.D.
W. R. VAN DEN BOSCH, M.D.
RICHARD WAGNER, M.D.
MORRIS D. WERTENBERGER, M.D.

Inter-Professional Relations

The Inter-Professional Relations Commission met October 17 and the following officers were elected:

Chairman: Dr. Paul E. Humphrey
Vice-chairman: Dr. Charles X. McCalla
Secretary: Dr. John W. Ripley

The first meeting of the commission was held December 8. The topics discussed at that meeting concerned a physician-pharmacist code of understanding which was adopted by the commission. There was considerable discussion on the matter of labeling prescriptions. The Commission on Inter-Professional Relations disagrees with the state medical council and did not recommend that all prescriptions be labeled. Our commission feels that the prescription should only contain those items as written by the physician.

Dr. Joe Davis of Marion discussed the possibility of a joint meeting between our commission and the Joint Committee for the Improvement of Patient Care. We felt that there were many aspects to be considered here and recommended that Dr. Davis continue to represent us at these meetings and report back any specific problem that we should become involved in.

Much time was spent on discussing how to improve our liaison with hospital administrations and nursing staffs, but no concrete recommendations were made.

Considerable time and thought was given to the establishment of a Department of Medicine and Religion for the state of Indiana. A temporary meeting was set up between our commission and the Reverend Doctor Paul B. McCleave. This meeting never materialized but our commission was invited to attend a meeting held at the State Board of Health where Dr. McCleave was the principal speaker. This meeting was well attended. The Commission on Inter-Professional Relations feels that the development of medical and religious relations should be fostered by all local county societies.

PAUL HUMPHREY, M.D., *Chairman*
CHARLES X. McCALLA, M.D., *Vice-Chairman*
JOHN W. RIPLEY, M.D., *Secretary*
JOSEPH D. McDONALD, M.D.
ROBERT H. RANG, M.D.
FRANK H. GREEN, M.D.
FLOYD A. BOYER, M.D.
ROBERT D. WILLIAMS, M.D.
FRED FLORA, M.D.
MILTON B. GEVIRTZ, M.D.
JOSEPH B. DAVIS, M.D.
JACK L. EISAMAN, M.D.
ROBERT H. DENHAM, JR., M.D.
NEAL E. BAXTER, M.D.
E. ROBERT JACOBS, M.D.

Medical Education and Licensure

The following is a narrative report on the past year's activities of the Commission on Medical Education and Licensure.

Following the organizational meeting in October, the commission met on numerous occasions during the next nine months. At the first meeting in November, it was decided that a number of projects be undertaken during the year and after a review of the pending business of the commission, these areas were thought to be the most advantageous to pursue: School Health, Postgraduate Education, Liaison with the Licensure Board of the State, Liaison with the University Faculty and a Preceptorship Program.

The commission was divided into small working groups to handle each of these projects and preliminary programs were made in each of the first three fields. Work on these projects is continuing through the remainder of the year and will continue to be a part of the business of the commission.

The latter two projects, due to the progress made, were deemed of utmost importance to the commission and we all proceeded to devote the major part of our time and energy to their fulfillment. Following a January meeting, a questionnaire devised by the commission was sent to each member via the *Newsletter*. Dr. George Lukemeyer of the university was made a member of the commission to further our efforts in the establishment of a preceptorship program. Dr. Richard McAlpine, of the preceptor committee of the I.A.G.P. was also made a member of this group to aid in avoiding duplication of work to the same ends.

In the March and May meetings, the working program for preceptorships, as reported to the presidents and secretaries of the component societies, was evolved. A second annual meeting with the medical school faculty heads and Acting Dean Nurnberger was planned for and held in July for the purpose of finalizing the plans for preceptorship and to exchange ideas on other topics of importance to the association and the university. The results of this meeting were very successful and fruitful in the minds of the members of both groups who attended. A meeting of similar nature is planned for 1965 and it is hoped may continue annually thereafter.

On the matter of the preceptor program, it is the wish of all of us on the commission that every member of the association via his county society do all that he can to foster and nourish this plan to the grand success that it can attain.

My personal thanks to each and every member of the group who contributed so unselfishly of his time and effort this past year.

PETER R. PETRICH, M.D., *Chairman*
JOEL SALON, M.D., *Vice-Chairman*
FORREST R. LaFOLLETTE, M.D., *Secretary*
JOHN STERNE, M.D.
WALTER VAUGHN, M.D.
I. S. TEMPLETON, M.D.
JAMES B. JOHNSON, M.D.
KENNETH E. SHERER, M.D.
LAWSON J. CLARK, M.D.
JOHN L. CULLISON, M.D.
LEO RADIGAN, M.D.
EARL W. BAILEY, M.D.
JAMES R. CARPENTIER, M.D.
HARRY KLEPINGER, M.D.
GEORGE T. LUKEMEYER, M.D., *Ex-Officio*

Special Activities

During the current year the Commission on Special Activities had an organizational meeting on October 17, 1963. Because of limited amount of business on hand and because of conflict on meeting dates on several occasions, no additional meetings were held this year.

For the year 1965 unfinished business on hand is a study of physicians as expert court witnesses on an amicus curiae basis.

ELI GOODMAN, M.D., *Chairman*
NORMAN M. SILVERMAN, M.D., *Vice-Chairman*
EARL W. BAILEY, M.D., *Secretary*
JOSEPH E. COLEMAN, M.D.
NORBERT M. WELCH, M.D.
JOHN SMITH, M.D.
ROBERT H. K. FOSTER, M.D.
JACK M. WALKER, M.D.
CLARENCE G. KERN, M.D.
ARTHUR KUHN, M.D.
DAVID C. GASTINEAU, M.D.
GUY B. INGWELL, M.D.
WES SHANNON, M.D.
JAMES D. KUBLEY, M.D.
ROBERT O. ZINK, M.D.

Aging

The Commission on Aging has held three meetings of the full commission, in addition to a subcommittee's efforts to develop aging "news" and explore the possibility of regular releases to the press and news media.

The commission took an active part in the statewide seminar on Cooperative Effort between Hospitals and Nursing Homes sponsored by the Joint Council to Improve the Health Care of the Aged.

The commission also, through the headquarters office of the Indiana State Medical Association, arranged for the production and distribution of over 150 copies of the proceedings of the statewide meeting on Cooperative Effort Between Hospitals and Nursing Homes held in November, 1963.

The commission continues to emphasize "Organized Home-Care Programs" at the community level as one of the essential facets of health services for the aged, particularly homemaker services which can help aged persons to utilize their capabilities to the fullest degree in personal and home care and for a more satisfying life. Because of these unique values, homemaker service should be available in every community.

Much progress has been made in homemaker services, especially in Vigo, Miami, Allen and Lake counties. More counties are studying different methods of setting these up and the commission will coordinate these activities as well as possible at the community level.

The commission also made arrangements to circulate to senior citizens groups throughout Indiana the AMA publication "More Life for Your Years." At present the publication is reaching 30 of these groups for a total distribution of 656 copies per issue.

In addition, the commission emphasized the need for local medical societies to recognize the many problems of the aged during its deliberations and to assume leadership in their counties in dealing with such problems. It was specifically pointed out that organized medicine's concern for "creeping socialism" in the area of care and treatment for the patient would be greatly strengthened through greater local county society participation and leadership in community projects dealing with the aged.

The commission further adopted a Resolution which recommended to the Council of the Indiana State Medical Association that they encourage the dean of the Indiana University School of Medicine to expose students to at least one lecture a year on gerontology. Action on this matter by the Council had not been undertaken at the time of this report.

LLOYD HILL, M.D., *Chairman*
GEORGE M. YOUNG, M.D., *Vice-chairman*
FRANK M. HALL, M.D., *Secretary*
L. JOHN VOGEL, M.D.
C. PHILIP FOX, M.D.
WILLIAM B. CLARK, Jr., M.D.
HARRY R. BAXTER, M.D.
WAYNE A. CROCKETT, M.D.
GLEN A. RAMSDELL, M.D.
WARREN ANDREW, M.D.
RALPH R. PLOUGHE, M.D.
F. S. CROCKETT, M.D.
NATHAN SALON, M.D.
N. C. JOHNS, M.D.
ANDREW C. OFFUTT, M.D.

Resolutions

Amendments to the Constitution to be voted on at Indianapolis Session, 1964.

At the 1963 annual convention at Indianapolis, the House of Delegates adopted the report of the Reference Committee on Amendments to the Constitution and Bylaws, in which the Reference Committee approved and recommended for adoption the following twelve amendments to the Constitution, as follows: (words or sections added are italicized).

(1). BE IT RESOLVED, that Article II of the Constitution of the Indiana State Medical Association be amended by deleting therefrom the following words "and to secure the enactment and enforcement of just medical laws."

As amended, said Article II would read as follows:

"The purposes of this Association shall be to federate and bring into one compact organization the medical profession of the State of Indiana, and to unite with similar societies of other states to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education; to promote friendly intercourse among physicians; to protect members against imposition; and to enlighten and direct public opinion in regard to the great problems of medical care, and public health, so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of diseases and in prolonging and adding comfort to life."

(2). BE IT RESOLVED, that Section 4 of Article IV of the Constitution of the Indiana State Medical Association be amended by deleting therefrom the last grammatical paragraph which reads as follows:

"All members who, previous to the adoption of this amendment to the Constitution, were certified as honorary members on the basis of the above qualifications, shall hereafter be classified as senior members" for the reason that said paragraph is no longer applicable to any existing situation.

(3). BE IT RESOLVED, that Section 6 of Article IV of the Constitution of the Indiana State Medical Association be amended by adding thereto immediately following sub-section b, a new subsection to be numbered c, as follows:

"c. *Senior members who desire the benefit of medical defense as provided by the Bylaws of this Association shall pay the amount stipulated in Section* 1, *Chapter XXIX of the Bylaws for this coverage.*"

Then renumber the present sub-paragraph "c" as sub-paragraph "d."

(4). BE IT RESOLVED, that Article V of the Constitution of the Indiana State Medical Association be amended by inserting after the word "treasurer" the words *"and assistant treasurer."*

(5). BE IT RESOLVED, that Article VI of the Constitution of the Indiana State Medical Association be amended by inserting after the word "vote" in the first sentence and before the period the words *"and assistant treasurer without power to vote except in case the treasurer be absent."*

(6). BE IT RESOLVED, that Article VI of the Constitution of the Indiana State Medical Association be amended by deleting therefrom the words "and at all times shall be the finance committee of the Association."

(7). BE IT RESOLVED, that Section 2 of Article VIII of the Constitution of the Indiana State Medical Association be amended by deleting the word "two" in the first sentence of said section and by substituting in lieu thereof the word *"five."*

(8). BE IT RESOLVED, that Section 3 of Article VIII of the Constitution of the Indiana State Medical Association be amended by adding thereto the following sentence, *"Upon receipt by the president of such a petition of twenty delegates, or fifty members, the president shall within* 30 *days thereafter issue a call for such special meeting at a time and place to be fixed by the president. The president, in specifying the time of such special meeting, shall fix the same as soon thereafter as reasonable and suitable arrangements can be made."*

(9). BE IT RESOLVED, that Section 1 of Article IX of the Constitution of the Indiana State Medical Association be amended by inserting after the comma, following the word, "treasurer" in said section the following *"assistant treasurer."*

(10). BE IT RESOLVED, that Section 3 of Article IX of the Constitution of the Indiana State Medical Association be amended by deleting therefrom the words "of the last day of the Annual Convention" and substituting in lieu thereof the following words *"at the final meeting of the House of Delegates."*

(11). BE IT RESOLVED, that Section 8 of Article IX of the Constitution of the Indiana State Medical Association be amended by inserting after the word "treasurer" the words *"or assistant treasurer."*

(12). BE IT RESOLVED, that Article XI of the Constitution of the Indiana State Medical Association be amended by inserting immediately after the word "the" and before the "Council" in the last sentence of said article the following words *"Executive Committee and."*

These amendments were presented in open meeting on October 14, 1964, and were published in *The Journal* of the Indiana State Medical Association, issues of September, 1963, and September, 1964.

Resolution No. 1

Introduced by: VANDERBURGH COUNTY MEDICAL SOCIETY

Subject: PROFESSIONAL RELATIONS BETWEEN DOCTORS OF OSTEOPATHY AND DOCTORS OF MEDICINE

WHEREAS, the adoption of criteria for determining the propriety of professional relations between Doctors of Osteopathy and Doctors of Medicine has been entrusted to the State Medical Associations by the American Medical Association, and,

WHEREAS, the Indiana State Medical Association has no formal basis upon which an individual physician may establish his decision to have such relations with an Osteopath except upon his personal judgment based on general guide lines, and,

WHEREAS, some formal technique in making such a determination in a given locality would be helpful to all of the physicians concerned, and,

WHEREAS, this would most likely be carried out with the greatest justice and fairness on a regional or a county level, and,

WHEREAS, specific programs for doing this could be done with the facilities already available in organized medicine and based upon the general principles already accepted by the AMA.

NOW THEREFORE BE IT RESOLVED, that the ISMA Commission on Inter-Professional Relations be entrusted with formulating a definite program whereby a county medical society (or societies) may determine which Osteopaths qualify for professional relations on an ethical basis, and,

BE IT FURTHER RESOLVED, that the Council of ISMA be authorized to adopt such recommendations of the Commission until the next meeting of the House of Delegates.

Resolution No. 2

Introduced by: VANDERBURGH COUNTY MEDICAL SOCIETY

Subject: CONTROL OF DRUG THERAPY

WHEREAS, the public should have protection from harmful effects of medications and therapeutic agents, and,

WHEREAS, every physician is entitled to full and prompt disclosure of all limitations, side-effects, hazards, and complications related to the use of therapeutic and diagnostic agents, and,

WHEREAS, the creative efforts of pharmaceutical organizations in providing new or improved products should not be hampered by unnecessary restrictive regulations, and,

WHEREAS, the practicing physicians must be allowed some latitude of judgment in the drug treatment of serious diseases where (frequently the more) potent or potentially toxic drugs may be necessary for the proper treatment of these diseases,

NOW THEREFORE BE IT RESOLVED, that the Vanderburgh County Medical Society urge the development of a reasonable and fair program with the FDA to insure equitable protection of all those whose interests are involved, and to insure that the medical profession will retain greater control and influence in the handling of drug therapy, and,

BE IT FURTHER RESOLVED, that techniques be formulated to provide alert recognition of risks by the medical and pharmaceutical professions, and on the other hand, to avoid undue alarm on the part of the public at large,

BE IT FURTHER RESOLVED, that the AMA be urged to expand its facilities to whatever degree is required to implement these objectives.

Resolution No. 3

Introduced by: FORT WAYNE MEDICAL SOCIETY

Subject: CONTROL OF BLOOD BANKS

WHEREAS, the medical profession has the primary responsibility for the care and treatment of patients, and,

WHEREAS, the procurement, storage, processing and administration of blood is part of the practice of medicine, and,

WHEREAS, a blood bank is a medical facility and the director must be a doctor of medicine, and,

WHEREAS, the responsibility of blood banking procedures can best be discharged by medical societies at the local level, and,

WHEREAS, it is highly essential that the organization of new blood banking programs, and the modification of existing ones should have, in the interest of public health and safety, the approval of the county medical society,

BE IT THEREFORE RESOLVED, by the House of Delegates of the Indiana State Medical Association that it favors enactment of legislation by the Indiana State Legislature to the effect that all blood banks must operate subject to the approval of the county medical society in which said blood bank is located, and,

BE IT FURTHER RESOLVED, that approval of new blood banks or modification of existing ones be subject to approval of the local county medical society, and,

BE IT FURTHER RESOLVED, that, at the appropriate time the position of the Indiana State Medical Association be made known to the members of the State Legislature, and,

BE IT FURTHER RESOLVED, that a representative of the Indiana State Medical Association appear before a committee of the State Legislature to which this resolution, or a similar resolution, be referred, and to urge its enactment by the Legislature of the State of Indiana.

Resolution No. 4

Introduced by: NEWTON COUNTY MEDICAL SOCIETY

Subject: TRANSFER OF NEWTON COUNTY MEDICAL SOCIETY FROM THE TENTH DISTRICT TO THE NINTH DISTRICT

WHEREAS, the Newton County Medical Society is in the Tenth District, and

WHEREAS, the shopping habits of the doctors' families are directed southward, and

WHEREAS, the division of time between Eastern and Central Standard Time is in Newton County, and

WHEREAS, the mode of living is more in keep-

ing with the Ninth District, and

WHEREAS, the doctors of Newton County voted to be transferred to the Ninth District,

THEREFORE BE IT RESOLVED, with these things in mind, the Newton County Medical Society be transferred from the Tenth District to the Ninth District.

Resolution No. 5

Introduced by: LESTER H. HOYT, M.D., delegate, Marion County

Subject: CREATION OF SECTION ON PATHOLOGY

WHEREAS, the Indiana Association of Pathologists is composed of in excess of eighty active members who are members of their component county medical societies and the Indiana State Medical Association, and

WHEREAS, these members have met almost annually for a luncheon during the annual convention of the Indiana State Medical Association, and

WHEREAS, they have and will take active part in the scientific portion of the annual convention, and

WHEREAS, the members of the Indiana Association of Pathologists at their annual meeting in 1963 approved requesting formulation of a section of the association—a section on pathology—in accordance with Article VII of the Constitution of the Indiana State Medical Association and under Chapter III, Section 1 of the Bylaws of the association,

THEREFORE BE IT RESOLVED: That a section on pathology be hereby approved and provided for by amendment of Chapter III, Section 1 of the Bylaws.

Scientific Exhibits

IRVIN H. SONNE, M.D., New Albany, Chairman

SMALL INDUSTRY: AN OPPORTUNITY FOR THE FAMILY PHYSICIAN

Exhibitor: AMA Council on Occupational Health

Attendant: Lee N. Hames, Assistant Director, AMA Council on Occupational Health

This exhibit attempts to acquaint the family physician with the different types of small plant health programs, and the part he can play in them. These programs range from very small operations in which the physician devotes only a small percentage of his time, to those in which he visits a plant on a frequent regular schedule. The exhibit tells how he can do a better job of caring for his working patient. Finally, the exhibit quotes the AMA House of Delegates to the effect that "organized medicine should exercise leadership in improving occupational health programs and in providing adequate health services for all employees, including those in small establishments."

NEWER CONCEPTS OF ABDOMINAL AND PELVIC ARTERIOGRAPHY

Exhibitors: T. R. Marshall, M.D., J. T. Ling, M.D., J. Amorocho, M.D., Department of Radiology, University of Louisville School of Medicine, Louisville, Kentucky

Attendants: T. R. Marshall, M.D., and J. Amorocho, M.D.

Newer concepts of abdominal and pelvic arteriography will be discussed. Our experience in over 600 brachial and axillary artery injections (noncatheter) and 200 transfemoral injections (Seldinger technic) will be explained. The brachial artery or axillary technic is preferred for the majority of conditions and especially in patients over 50 years or persons with vascular disease of the iliac or femoral vessels.

YOU AND YOUR CIVIL DEFENSE

Exhibitor: Indiana Department of Civil Defense

Attendant: Mrs. Josephine Bicket

Fallout Shelter supplies

Medical Self-Help Kits

Radiological equipment

THREE YEAR STUDY OF MANAGEMENT OF PEPTIC ULCER

Exhibitor: Fred J. Phillips, M.D., Quakertown, Pennsylvania

Attendant: Fred J. Phillips, M.D.

To test under controlled conditions over a three year period the efficacy of a regimen for minimizing the frequency and severity of peptic ulcer attacks in individuals with proven ulcers. The regimen consists of antacids, bland diet and an anticholinergic drug. Other therapy is also discussed. The criteria used are: time to bring ulcers under control, duration of hospitalization and those requiring special medical care in addition to the recommended regimen. The concept of a specific, rational approach to peptic ulcer has proven most successful as compared to an empirical type of therapy.

LYMPHOGRAPHY—EXPERIENCE WITH 350 CASES

Exhibitor: Patrick A. Dolan, M.D., Methodist Hospital, Indianapolis

Co-exhibitors: M. D. Anderson Hospital, Houston, Texas, and Methodist Hospital, Indianapolis

Attendant: Patrick A. Dolan, M.D.

Lymphography has been used by the author in the investigation of more than 350 patients at the University of Texas M. D. Anderson Hospital and Tumor Institute, Houston, Texas and Methodist Hospital, Indianapolis, Indiana. The majority of these patients had, or were suspected of having, malignant disease, but a number of benign conditions were also seen.

Retroperitoneal lymphography can aid quite remarkably in the diagnosis of retroperitoneal disease, in mapping the extent of suspected lymphoma, and in depicting metastases from malignancies involving the lower limbs, genitalia, and pelvic organs. Axillary lymphography serves a similar purpose in a different site. The pattern of the lymphogram in the presence of carcinoma, lymphoma, and benign inflammatory disease will be illustrated. Some of the pitfalls leading to errors in diagnosis will be pointed out, and the accuracy achieved in a large series discussed.

The study can be performed in any hospital radiographic department. The technic, though simple, is somewhat time consuming. The technic and equipment used by the author will also be demonstrated.

5-FLUOROURACIL IN CANCER

Exhibitor: Michael J. Brennan, M.D., Division of Oncology, Henry Ford Hospital, Detroit, Michigan

Co-exhibitors: R. W. Talley, M.D., Division of Oncology, Henry Ford Hospital; V. K. Vaitkevicius, M.D., Detroit

Attendants: J. Burrows, M.D., E. San Diego, M.D., R. Talley, M.D., M. Brennan, M.D.

Twenty percent of 200 selected patients with ovarian, mammary, or colonic cancer experienced tumor regressions after 5-Fluorouracil. Mean survival of responders was slightly longer (four months) than for non-responders. Alopecia, stomatitis, and pancytopenia regularly followed treatment.

Contraindications, management of complications, and method of dose-determination are presented.

FLYING PHYSICIANS ASSOCIATION, INDIANA CHAPTER

Exhibitor: Indiana Chapter, Flying Physicians Association

Attendants: M. F. McGrath, M.D., Robert M. Butterfield, M.D., Dan L. Urschel, M.D.

The Flying Physicians Association is an international organization comprised of more than 1600 physician-pilots in the United States, Canada, Australia, West Germany, Venezuela, etc. It was organized for the promotion of flight safety, and for the education of pilots in general concerning the relationship of medical problems and aviation. Not only are they primarily concerned with many aspects of flight safety, but they work also in other fields of aviation. A Disaster Program is available whereby the members of the organization can gather at any designated spot on brief notice, to utilize their aircraft and their professional skills in the case of any emergency.

The Indiana chapter is made up of more than 110 members, and has shown a steady growth from a membership of less than half that number five years ago. The Indiana group has been particularly active in the Disaster Program, holding many such previously unannounced alerts, through the cooperation of the Indiana State Police, who have handled the notification system. Indiana has always been active in the national organization, and of nine men who have held office as president since the formation of the organization in 1955, two have been from Indiana.

PRELIMINARY EVALUATION OF A RAPID DIABETES DETECTION TEST

Exhibitor: Jack H. Hall, M.D., Methodist Hospital, Indianapolis

Co-exhibitors: George W. Applegate, M.D., Marvin Dziabis, M.D., William Dugan, M.D., Methodist Hospital, Indianapolis

Attendants: Exhibitors as mentioned above

A new method for the detection of diabetes by use of a glucose tolerance test has been devised. A 75 gram glucose load was supplied by a carbonated cola solution.* Blood glucose levels were determined by a new quantitative glucose stick** utilizing semipermeable cellulose empregnated with glucose oxidose and a catalyst chromagen. Values are then read from a color chart. The test procedure is outlined in the display.

One hundred glucose tolerance tests were performed on random outpatients. The acceptability of the glucose load is evaluated and the stick determinations are compared to glucose autoanalyzer results.

Glucola and Dextrostix will be on hand for demonstration.

* Glucola—Ames Company

** Dextrostix—Ames Company

"EXPLORING" MEDICINE AS A VOCATION

Exhibitor: William M. Dugan, M.D., Indianapolis

Co-exhibitor: James R. Spindler, M.D., Indianapolis

Attendants: Exhibitors, plus three Explorer Scouts

Methodist Hospital Graduate Medical Center is one of three institutions in Marion County currently sponsoring a medical Explorer Scout post. The explorer specialty program was established in cooperation with the Indianapolis Medical Society and the Central Indiana Boy Scout Council to offer high school boys a chance to explore various fields of medicine and medical research.

Each explorer post planned individual programs in addition to eight general sessions with all posts participating. Explorer Post 297 met bimonthly during the months of December through May. The post is currently composed of 23 members from eight Indianapolis high schools. Highlights of the past school year included at least one night observing in the emergency rooms of either Marion County General Hospital or Methodist Hospital. Nearly every Scout passed a six weeks Standard First Aid Course offered by the American Red Cross.

An exhibit on blood banking was the final project of the past school year. It was shown with the 1964 Boy Scout Fair and received a first award. This Scout exhibit is being shown with the Indiana State Medical Association meeting to stimulate interest in medicine among young people.

INDIANA STATE ASSOCIATION OF MEDICAL ASSISTANTS

INDIANA'S ACTION FOR MENTAL HEALTH—A PHYSICIAN-CENTERED PLAN

Exhibitor: Indiana Department of Mental Health, Indianapolis

Attendants: Robert H. Branson, Peter von Stein, Michael Birky, Daniel Steiner

The display outlines a grass-roots approach to comprehensive mental health services and depicts how Indiana counties can band together to solve regional problems.

The display also outlines the work of the Indiana Mental Health Planning Commission, 11 task forces for expert study in problem areas, and how local action will be taken to meet regional service areas.

Brochures of Indiana's Action for Mental Health and a progress report of the planning commission will be available at the booth for all visitors.

DIAGNOSIS OF SUPRARENAL MASS LESIONS BY RETROPERITONEAL AIR STUDIES AND ARTERIOGRAPHY

Exhibitor: Erich K. Lang, M.D., Methodist Hospital, Indianapolis

Co-exhibitors: Myron Nourse, M.D., Donald McCallum, M.D., William Niles Wishard, M.D., Methodist Hospital

Attendants: Erich K. Lang, M.D., Myron Nourse, M.D., Donald McCallum, M.D., William Niles Wishard, M.D.

The diagnosis of suprarenal mass lesions is greatly advanced by special roentgenographic examinations performed in the following order of preference: flat plate of the abdomen, intravenous pyelogram, upper G.I. series, retroperitoneal carbon dioxide or nitrous oxide study and arteriograms.

The exact anatomical location of the lesion as well as the relationship to adjacent structures is readily identified by these examinations. A histological diagnosis is often suggested by retroperitoneal carbon dioxide or nitrous oxide studies and particularly by the characteristic arteriographic pattern of some of these lesions.

Direct puncture of cysts, sequestration studies of red cells tagged with Chromium 51 and lymphangiography are recommended as auxiliary means of study. The correct preoperative diagnosis was made in 53 out of 57 patients in this series.

STRESS FRACTURES OF THE LOWER EXTREMITIES

Exhibitor: George F. Rapp, M.D., Indianapolis

Co-exhibitor: William M. Hebble, M.D., St. Vincent's Hospital, Indianapolis

Attendants: George F. Rapp, M.D., William M. Hebble, M.D.

Stress, fatigue, or march fractures may be defined as fractures which occur in normal bone due to repeated minor injury; no trauma is experienced which might cause a fracture of normal bone to occur. Stress fractures differ from pathologic fractures in that the latter occur in bone weakened by disease or other pathologic processes.

March-foot was described in the wars of Napoleon. Stress fractures have been more thoroughly understood since the advent of x-rays. These fractures are seen in civilian practice and can be a diagnostic problem.

The exhibitors have treated approximately 800 stress fractures during the last two years at Fort Jackson, an Army basic training center at Columbia, S. C.

X-rays demonstrating typical early and late bone changes in cases of stress fractures of the metatarsals, os calcis, tibia, fibula, femur and hip will be exhibited and treatment outlined for the various types of fractures.

HEART ASSOCIATION ADVANTAGES FOR PHYSICIAN MEMBERS

Exhibitor: Indiana Heart Association, Inc.

Attendants: Frederic H. Weigle, H. Carl Smith, Earl B. Beagle

This exhibit is intended to show the many aids for physicians and their patients that are available through the Indiana Heart Association and its chapters. It is also intended to bring to the attention of physicians, the opportunities that they, as members of their local, state, and national Heart Association, have for continuing education.

Technical Exhibitors

(Letter prefix denotes aisle)

ABBOTT LABORATORIES Booth D-20
14th and Sheridan Rd. North Chicago, Ill.

AKRON SURGICAL HOUSE, INC. Booths B-3 & B-5
1927 N. Capitol Ave. Indianapolis 2, Ind.

AMERICAN CANCER SOCIETY Booth D-1
215 E. New York St. Indianapolis, Ind.
S. Miles Standish, D.D.S., William T. Mabrey

AMERICANA CORPORATION Booth B-18
291 S. LaCienega Blvd. Beverly Hills, Calif.

AMES COMPANY, INC. Booth C-22
819 McNaughton Ave. Elkhart, Ind.
William Furrow

ARNAR-STONE LABORATORIES, INC. Booth B-20
225 E. Prospect Ave. Mount Prospect, Ill.
W. H. Snider, Wayne Snyder

ASTRA PHARMACEUTICAL PRODUCTS, INC. Booth D-29
7 Neponset St. Worcester 6, Mass.

AYERST LABORATORIES Booth B-15
7545 N. Natchez Ave. Chicago 48, Ill.
L. R. Martin, M. L. Gurchiek, S. A. Muir, T. J. Wise, J. C. Long

BAKER BROTHERS, INC. Booths C-24 & C-26
2039 N. Capitol Ave. Indianapolis 2, Ind.

BAKER LABORATORIES, INC. Booth B-2
3940 Euclid Ave. Cleveland, Ohio
Bill Cody, Marc Connor

BIO-DYNAMICS, INC. Booth B-11
1640 N. Ritter Ave. Indianapolis, Ind.
Ronald White, Joe Borders, Ray Kiess

BLACK & SKAGGS ASSOCIATES, INC. Booth L-7
(Professional Management)
181 North Ave. Battle Creek, Mich.
Harold L. Neff, Paul D. Evans, L. Thomas Booth, John B. Hogan

BREWER & COMPANY, INC. Booth D-13
67 Union St. Worcester, Mass.
Sidney L. Segel

BRISTOL LABORATORIES Booth D-15
P. O. Box 657 Syracuse 1, N. Y.

BURROUGHS WELLCOME & CO. Booth D-23
1 Scarsdale Rd. Tuckahoe 7, N. Y.

CENTRAL BRACE COMPANY Booth C-23
1618 N. Illinois St. Indianapolis, Ind.
Kermit K. Taylor, Miles A. Hobbs

CIBA PHARMACEUTICAL COMPANY Booth D-31
556 Morris Ave. Summit, N. J.

THE COCA-COLA COMPANY Booth B-25
P. O. Drawer 1734, 310 North Ave., N.W.
Atlanta 1, Ga.

F. E. COMPTON & COMPANY Booth B-17
1000 N. Dearborn St. Chicago 10, Ill.
A. Payne, C. Erdman, R. Weil, P. Foster, R. Ippolito, D. Miller

CONTOUR SALES, INC. Booths B-8 & B-10
3728 E. 38th St. Indianapolis, Ind.
Ed C. Olin, Bertie Bewley, Virginia Schell

THE GEORGE F. CRAM COMPANY, INC. Booth E-1
730 E. Washington St Indianapolis, Ind.
James Barnhart, L. B. Douthit

CURTIS AND FRENCH, INC. Booth C-6
444 W. 16th St. Indianapolis 2, Ind.
C. E. McCain, D. F. Curtis, Don Graves

DAIRY COUNCILS OF INDIANA Booth D-30
50 S. Parker Ave. Indianapolis 1, Ind.
Mrs. Lillian E. Staub, Mrs. Barbara T. Morley, Mrs. Lois Smith, Mrs. Hazel Burnett

DOME CHEMICALS, INC. Booth A-14
125 W. End Ave. New York 23, N. Y.

ENCYCLOPAEDIA BRITTANICA, INC. Booth D-10
425 N. Michigan Ave. Chicago 11, Ill.

ENDO LABORATORIES, INC. Booth C-3
1000 Stewart Ave. Garden City, N. Y.
Bob Radford, Gene Hering

MARSHALL ERDMAN AND ASSOCIATES, INC. Booth C-2
5117 University Ave. Madison 5, Wisc.
Don Brickson, Hi Walker

GEIGY PHARMACEUTICALS Booth B-1
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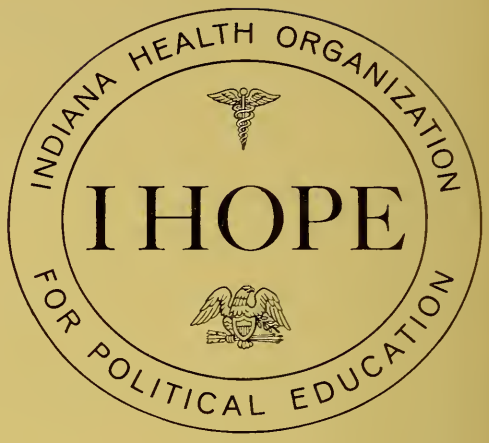
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Abstracts of Educational Films To be Shown at ISMA Convention

OTOSCOPY IN THE INFLAMMATIONS
(Ayerst)

A series of tympanic membranes is presented from the acute and chronic catarrhal conditions to the adhesive processes. Differentiations between the various types of chronicity are analyzed and discussed.

GLAUCOMA: WHAT THE GENERAL PRACTITIONER SHOULD KNOW
(AMA No. 84)

This film has been made to bring home to the general practitioner the high incidence of blindness due to glaucoma so that he will be on the watch for signs and symptoms of its existence in his patients; to show him how to recognize these signs and symptoms and to point out the necessity of referring such patients to an ophthalmologist for definite diagnosis and treatment.

MICROBIAL SUSCEPTIBILITY
(Roerig)

This film is based on a recent nation-wide study of microbial susceptibility in 66 hospitals. During a ten-week period, investigators in the hospitals isolated 9,331 cultures of four types of bacteria from patients with overt clinical infections and tested these cultures for susceptibility to five antibiotics. The film covers the highlights of this study.

MEDIFILM REPORT No. 5
(AMA Annual Meeting, Atlantic City, 1963)

Highlights of the 1963 AMA annual meeting with interesting recent medical developments reported by physicians in practice and research. Includes discussions on New Implantable Cardiac Pacemaker, Assisted Circulation by Counterpulsation, "Painless" Myocardial Infarction, Status Asthmaticus, The Hand in Differential Diagnosis of Rheumatoid Arthritis, Tetanus and its Prevention, Gastric Freezing for Peptic Ulcer and Project HOPE and other overseas medical activities.

CANCER TREATED BY ARTERIAL INFUSION CHEMOTHERAPY
(Lederle H-27)

The film shows the use of anti-cancer drugs in high concentration in a localized site, and shows steps taken to infuse the liver in treatment of a primary tumor. An interesting photographic sequence shows the proper placement of the catheter in the artery used for infusion. Also shown is the technic for use of a fluorescein dye and ultraviolet light to obtain accurate knowledge of the area infused.

NO REAL PATHOLOGY
(Upjohn)

If yours is a typical practice, approximately four out of 10 patients who come to you have no symptom-related pathology. In this film designed for postgraduate education, a psychiatrist points out that most of these patients can be treated by the physician who sees them first. The principal requirement is a differential diagnosis to determine whether the underlying cause is primarily depression or anxiety. To help the non-psychiatrist make this diagnosis, six basic questions are presented and the typical response patterns shown which facilitate diagnosis.

THE FACES OF DEPRESSION
(Geigy)

A new kind of film in which patients collaborate in the description of their conditions. They are seen and heard in unrehearsed interviews. Since in diagnosing depression, the physician must depend on what he observes and on what the patient tells him, this filmed document should help him in dealing with his own patients. It makes no attempt to classify different kinds of depression, but concentrates rather on recognition of the syndrome.

THE MEDICAL WITNESS
(AMA No. 144)

In vivid, dramatic scenes, this film shows examples of two physicians offering medical testimony on which the plaintiff's suit depends. One physician shows the right way and the second, the wrong way.

DIAGNOSIS AND MANAGEMENT OF FUNGOUS INFECTIONS OF THE SKIN, HAIR AND NAILS
(Schering)

This film emphasizes the clinical aspects of superficial fungous infections and should be of particular interest to dermatologists, internists, pediatricians and general practitioners. The clinical aspects are discussed on the basis of the body area involved and particularly interesting cases are presented. The status of therapy with griseofulvin and its mode of action are discussed and the difficulty of diagnosing these infections by visual means alone is amply demonstrated.

ANORECTAL AND SIGMOIDOSCOPIC EXAMINATION WITH DIFFERENTIAL DIAGNOSIS
(Ayerst)

This film emphasizes the importance of anorectal and sigmoidoscopic examination of the colon in detection of carcinoma. Benign and premalig-

nant lesions of the rectum and sigmoid colon are visualized. The proper technic for use of proctoscope and sigmoidoscope in examination is explained and illustrated by anatomical art.

LIGATION OF THE INTERNAL ILIAC (HYPOGASTRIC) ARTERIES
(Armour)

This film focuses the attention of those who perform pelvic and obstetrical operations on the fact that serious hemorrhages are still among the principal causes of death in the United States. The discussion covers surgical anatomy, collateral circulation, definitive and prophylactic indications, surgical technic and postoperative care. The anatomy and surgical technic are graphically presented; first by dissection of a cadaver and then through actual surgery.

REDUCTION MAMMAPLASTY FOR PENDULOUS BREASTS
(Armour)

The sad plight of the woman with massive, pendulous breasts is not widely appreciated. This film attempts to acquaint the general practitioner with the therapeutic measures available to these women. It demonstrates actual transplantation of the nipples, followed by bilateral partial mastectomy, and includes postoperative results of over 15 years, showing the "takes" of the nipples with the erectile tissue intact.

MANAGEMENT OF MASS CASUALTIES, PART 11: BURNS
(U. S. Department of the Army Disaster Medical Care Film)

Describes the operating principles in the management of burn casualties under nuclear disaster conditions where a disparity exists between medical requirements and available medical facilities. Salient teaching points cover self-care, electrolyte therapy, transfusion, exposure method of treatment of radiation symptoms and surgical technics employed in the excision of burned tissue.

MANAGEMENT OF MASS CASUALTIES, PART 6: SORTING
(U. S. Department of the Army Disaster Medical Care Film)

Discusses problems associated with the identification of various types of casualties likely to be encountered in nuclear weapon warfare, where the medical personnel and facilities available are inadequate to meet the medical requirements. Describes the four major classifications into which the injured will be sorted for treatment—minimal, immediate, delayed and expectant treatment.

EXTERNAL CARDIAC MASSAGE
(AMA No. 219)

Describes the recently developed technic whereby hearts that have stopped beating may be started again without opening the chest. Shows the steps that may be taken to resuscitate patients when heart arrest or ventricular fibrillation occurs outside the hospital as well as inside the hospital.

RESUSCITATION FOR CARDIAC ARREST
(Squibb)

Unpredictable cardiac arrest occurs several times each year in every large hospital. This catastrophe may complicate any type of operation and may also occur in non-surgical patients. Every physician, and especially every surgeon and anesthetist can expect to encounter cardiac arrest at some time during his professional career. The purpose of this film is to help formulate a plan for action for such an emergency by presenting the basic principles of what might be called a "cardiac resuscitation fire drill."

HEAD INJURY, GRAND ROUNDS #10
(Upjohn)

A skull fracture complicated by blood clots is presented at successive stages of the case history. At each stage, panelists are asked to recommend a course of therapy. The cardinal signs of impending danger in the patient with head injury are emphasized.

INNOVATIONS IN TRANSFUSION THERAPY
(Fenwal)

Designed specifically to acquaint the clinician and blood banker with the progress in the field of transfusion therapy. The film is directed toward better understanding of transfusion of whole blood and its components; their proper use; their hazards and their benefits. To illustrate the depletion of various blood components, photomicrographs of the circulation in hamster cheek pouches are shown.

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PRECAUTION: Reduction in dosage of Arthralgen-PR given over a long period should be gradual, never abrupt.

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SUPPLY: Arthralgen (white, scored) and Arthralgen-PR (yellow, scored) tablets are available in bottles of 100 and 500.

*Cohen, et al: J.A.M.A., 165:225, 1957.

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Medicine At Law

DECISIONS AND OPINIONS

Highlights of recent court actions pertaining to health and medicine from *The Citation* prepared by the Law Division of AMA.

Fluoridation of City Water Upheld as Necessary to Public Health—Artificial fluoridation of the water supply of the city of Chicago was upheld by the Supreme Court of Illinois as a public health measure. Dismissal of a taxpayers' action to enjoin fluoridation was affirmed.

Fluoridation was decided upon, after public hearings, by a committee appointed by the City Council. The council passed a resolution approving fluoridation in the interest of public health. The program was carried out with the approval of the Illinois Department of Public Health.

Shortly after the program went into effect, the plaintiffs, suing as taxpayers and users of the city's water system, brought suit for injunctive relief. The complaint was dismissed pursuant to the recommendations of a master in chancery. The master made three basic findings of fact: (1) that fluoridation reduces dental caries by 60% in children up to 14 years of age; (2) that fluoridation of one part/per million parts of water will not cause mottled teeth; and (3) that fluoridation to such extent will not cause systemic physical harm to the population as a whole.

The court rejected the plaintiffs' contention that the master's findings were not supported by the weight of the evidence. At best, the court said, there was merely a debatable question as to the harmful effects of fluoridation in the matter of mottled teeth. However, that was a matter in which legislative judgment must prevail. The court concluded that artificial fluoridation of water is reasonably related to public health, and that the program adopted by Chicago was necessary and suitable for the protection of public health. The police power of a city may be used for public health purposes, and a valid city regulation will not be disturbed unless it is clearly arbitrary or unfair.

The court said that fluoridation did not amount to class legislation, even though it directly benefited only children in the six-to-14 age group, since its benefits carried over into adulthood. The fact that tooth decay is not a communicable or epidemic disease was likewise immaterial, since a city may adopt reasonable measures to improve or protect public health even though communicable or epidemic diseases are not involved.

The taxpayers also charged that the Chicago program was arbitrary and unreasonable because it was wasteful and was administered in a haphazard manner. The court disagreed, holding that the fact that fluoride content varies, not always being exactly one part/per million parts of water, does not result in harmful effects, since the specified ratio is usually achieved. Absolute perfection, the court said, is impossible to attain. As to wastefulness, the court concluded that the public expense was more than offset by the beneficial effects to the entire population.

The court affirmed the trial court's assessment of half the master's fees and charges to the city of Chicago. The apportionment was not an abuse of discretion, the court decided, since the taxpayers' action was filed in good faith at a time when the constitutionality of the program was uncertain.

Schuringa v. City of Chicago, 198 N.E. 2d 326 (Ill., Mar. 18, 1964).

Motorist Liable for Injuries to Another may Collect Indemnity from Doctors for Negligent Treatment—A motorist who negligently injured a person would be liable for that person's subsequent death as a result of the injuries, but if the death were caused by the negligence of attending physicians, then the motorist is entitled to idemnity from the physicians. A California apellate court, reversing a trial court, based its decision on equitable grounds, pointing out that the physicians were chosen by the decedent, and not by the motorist.

It was undisputed that the motorist's negligent conduct caused injury to the decedent. However, it was not until 18 months after the accident that surgery was decided upon. In the course of the operation, a blood transfusion was administered to the patient. On the day following her admission to the hospital, the patient died, allegedly as the result of negligent administration of the transfusion by the doctors and the hospital.

At the time of the patient's death, an action filed by her against the motorist for personal injuries was pending. Thereafter, an action for wrongful death was brought. Since the doctors and the hospital could not be charged in the wrongful death action for any damages caused by the motorist, the motorist sought indemnity from them for their alleged negligence.

The court ruled that the motorist was entitled to such indemnity, since he had no control over the actions of the doctors or the hospital, yet he was liable in law for any damages caused by them. Under such circumstances, it was only fair that they bear that portion of the damages caused by their own negligent conduct.

The court also reversed the trial court's dismissal of a cross-complaint filed by one of the doctors against the other doctors and the hospital, seeking indemnity from them on the ground that they were his agents. The court agreed that a principal is entitled to indemnity for an agent's negligent acts. However, the court found no special relationship among the defendants which would justify indemnity in the absence of a principal-agent relationship.

Herrero v. Atkinson, 38 Cal. Rptr. 490 (Cal., May 6, 1964). ◄



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Blue Shield Offers to Underwrite Kerr-Mills

(One of a series prepared by Blue Shield)

According to reports from Washington, Chairman Wilbur Mills (D.-Ark.) of the House Ways and Means Committee, will allow the King-Anderson bill (Medicare) to die in committee in favor of proposals of his own.

Evidence grows that Rep. Mills' committee will recommend increasing social security cash benefits and expanding the Kerr-Mills act (Medical Assistance for the Aged) as a substitute for Medicare.

If the reports are true, it appears that the overwhelming opposition to Medicare in this country has convinced the committee that Americans prefer voluntary prepayment of their health care needs.

The National Association of Blue Shield Plans reports that over 77% of the United States population already has some form of voluntary health care prepayment protection. The American people have voted, overwhelmingly, with their dollars for the voluntary method of paying their medical expenses.

Upon attaining 65, people do not automatically want to become wards of the government as the administration has assumed in backing Medicare. Provided they have sufficient funds, the majority of individuals over 65 would prefer prepaying their medical care as they did before reaching that age.

The one real problem existing is that some of the people over 65 do not have the money to purchase a reasonably good health care prepayment plan for themselves.

The only necessary function of the federal government is to provide for people who cannot provide for themselves. These disadvantaged citizens can then obtain necessary medical care in much the same way as their more favored friends and neighbors.

However, by providing funds to the aged through social security, the government will be excluding four to five million aged not covered by social security . . . and many of these are in the "needy" category. The other method under consideration by the committee, by expansion of Kerr-Mills, is a well-founded suggestion.

Increased effectiveness of the Kerr-Mills act will be far more effective than increased social security benefits and much less costly than a compulsory government health program for all aged whether they need assistance or not.

Blue Shield feels that Kerr-Mills can be improved by amending it in such a way as to promote and encourage the use of voluntary prepayment plans for underwriting the benefit program. These amendments would permit needy elderly people to avail themselves of the services of their own freely chosen physicians without a test of their "means" at the time services are needed.

Blue Shield says that by adapting Kerr-Mills to the voluntary structure, Congress not only would strengthen the Kerr-Mills program, but would also make a tremendous contribution to the security and strength of America's entire voluntary health care prepayment plans. By utilizing the prepayment plans, Congress would also achieve a stability and predictability of cost for the Kerr-Mills program available in no other way.

By providing proper funds for the needy elderly, the government will enable voluntary health care prepayment plans to provide for the health care needs of all elderly, while maintaining the independence which they value so much. ◄

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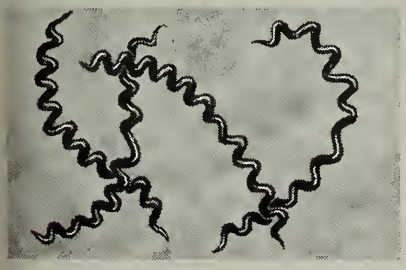
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Pian is a disease that is contagious in the tropics but apparently never infectious in other areas. Caused by *Treponema pertenue,** it is often acquired during childhood and is widespread among native tribes such as the Babinga, a race of forest pigmies in Ubangi. The organism enters the body through cuts or abrasions of the skin, usually by direct contact, but flies, especially species of *Hippelates,** can also transmit the disease. Within three to four weeks a granulomatous lesion (the "mother pian"*) develops at the site of inoculation. Six to twelve weeks later a generalized eruption occurs. After several years, tissue-destructive tertiary lesions of the skin and bones may be seen. Disfiguring and disabling, these lesions are both a social and economic handicap to many adult patients. Diagnosis rests on appearance of lesions, history of contact, and identification of the spirochete on dark-field examination or by Giemsa-stained smear. A positive reaction to serologic tests for syphilis is also obtained, although pian is not a venereal disease. **illustrated*







SIDE EFFECTS: Glossitis and allergic reactions have been reported as rare side effects. Use of oxytetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth.

PRECAUTIONS: Overgrowth of nonsusceptible organisms may occur. In such cases, discontinue medication and institute appropriate specific therapy as indicated by susceptibility testing. Aluminum hydroxide gel given with antibiotics has been shown to decrease their absorption and is contraindicated.

FORMULAS: Terramycin Capsules: oxytetracycline HCl, 250 mg. and 125 mg.; Terramycin Syrup: calcium oxytetracycline, 125 mg. per 5 cc.; Terramycin Pediatric Drops: calcium oxytetracycline, 100 mg. per cc.

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ABSTRACTS

BOOK REVIEWS

CANCER OF THE FEMALE REPRODUCTIVE ORGANS

Alfred L. Sherman, M.D., C. V. Mosby Co., St. Louis, 1963. 338 pages. $3.75.

When one reads this book one is impressed by the excellence of the presentation of material. Although it is a small book, it covers a more extensive area of knowledge of pelvic cancer than one will find in many voluminous works.

The author has aimed at writing a book concisely, presenting the essential principles of therapy of gynecologic cancer. It is not a textbook; gross and microscopic pathology is not included, nor is operative technic, except for one chapter devoted to some seldom mentioned but important features of pelvic surgery. Only diagrammatic illustrations are used, and these to illustrate principles and technic of radiation. This book fills a recognized void of literature between a reference book and a classical textbook, and is an introduction to radiotherapy for the gynecologist.

The material in the book is divided into 15 chapters. Following each chapter there are a few references — but not the usual unnecessarily long bibliography. The index is sufficiently complete. Cervical cancer being the most common pelvic malignancy, 134 pages are devoted to the subject, and 59 pages to radiotherapy of cervical cancer. Since the greater part of radiation therapy in this country is performed by therapists and not gynecologists, some gynecologists may consider the discussion of the subject in this book to be superfluous.

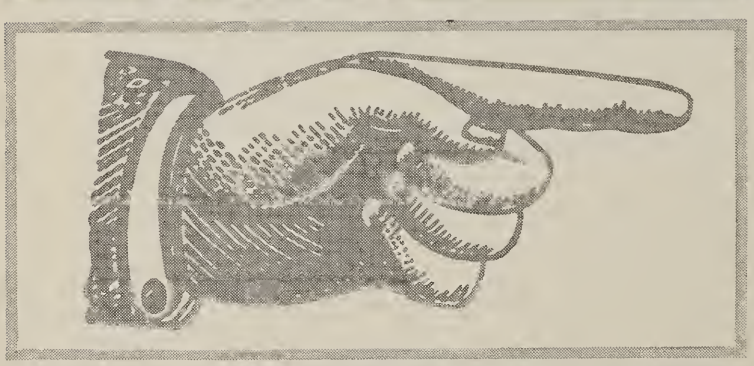
The second chapter takes up the basic principles of the physics of radiation in an admirable fashion for the non-expert. All of the discussion of radiotherapy would be considered desirable if not practical knowledge for any well-rounded gynecologist. It is to be expected that radiation therapy is stressed, since this work comes from a clinic which for many years has been outstanding in radiation treatment of cancer. Nevertheless, all recognized forms of therapy of pelvic malignancy are considered and evaluated without bias. One chapter presents very useful information pertaining to nursing care of patients with gynecologic cancer, and another is devoted to medical statistics.

All of the material is current. For instance, an interesting and novel report is of six cases of cervical carcinoma in pregnancy of over 18 weeks treated by radiation, allowing the pregnancy to continue. All infants were delivered at term and appeared to be normal. Few obstetricians have attempted such a heroic procedure.

The opinions expressed in the book are authoritative and the subjects are adequately covered. The brevity, clarity and simplicity of the writing of the



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text are impressive. It is an exceptional work and should be in the library of all radiotherapists and gynecologists, and also should be available to students and residents.

DAVID A. BICKEL, M.D.
South Bend

THE MAXILLARY SINUS IN ORAL SURGERY

Richard M. Herd, J. Thayer Waldo (3989 Meadows Dr., Indianapolis)
J. Ind. S. Dent. Assoc., 43:277 (June-July), 1964.

Development of a fistula between the maxillary antrum and the socket of a tooth extracted from the posterior maxillary arch is the most common complication of extractions from the upper jaw. Extracted teeth should always be examined to prove that all the roots are removed and the socket should be carefully visualized in this area to determine whether an opening has been made into the sinus or whether the thin plate of bone has been removed, thus leaving only mucosa between the socket and sinus with tendency to fistulate later.

Immediate treatment is to suture the socket margins. Mucoperiosteal flaps may be required and alveolar bone may need to be removed to achieve a complete closure. An antral fistula of long standing requires more mobilization of soft tissues. This may be done by the use of a modified Bard-Parker stab blade. The blade is heated to red heat and the last 1 mm. of the point is turned at a right angle by the use of a hemostat. This blade is used to mobilize a mucoperiosteal flap from the maxillary bone, and after the sinus has been denuded of mucosa and scar, the flap is sutured over the opening. Ice packs and anti-inflammatory tablets are used to control edema. Blowing the nose and sneezing is forbidden. Antibiotics should be given for three or four days.

Abstracted by
FRANK B. RAMSEY, M.D.
Indianapolis

Abstracts From Various Literature, Prepared by AMA

MATERNAL ATTITUDE TO PREGNANCY INSTRUMENT

A. Blau (1176 Fifth Ave., New York), J. Welkowitz, J. Cohen, *Arch. Gen. Psychiat.* 10:324 (April) 1964.

A preliminary report is presented of a research test, the maternal attitude to pregnancy instrument (MAPI), devised to investigate the possibility of predicting psychogenic obstetrical complications. It was also translated into Spanish for use with a special clinic population. The test is based on the hypothesis, substantiated partly in a retrospective study of mothers of prematures, that the

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ences with 13 cases treated surgically at Cook County Hospital during the past four years suggest that prevailing concepts of the incidence, pathogenesis, diagnosis, and management need reappraisal. The clinical and operative findings in these patients are presented, and disappointing experiences with esophagoscopy, balloon tamponade, gastric hypothermia, and empiric gastric resection in the detection or control of bleeding are recounted. Suture repair of the cardial laceration through a long exploratory gastrotomy incision is recommended as the treatment of choice when bleeding proves excessive. The mortality rate of 46% is believed to reflect delay in surgical intervention and in the high incidence of associated disease, especially chronic alcoholism.

ANTIBODY TO MILK AND SUDDEN DEATH

E. Gold (3395 Scranton Rd., Cleveland Heights, Ohio), L. Adelson, G. K. Godek

Pediatrics 33:541 (April), 1964.

The titers of antibody to cow's milk proteins were measured in four groups of children: (a) infants dead of known causes, (b) infants who died from the sudden death syndrome, (c) well babies fed cow's milk formulas exclusively, and (d) well babies fed both cow's and human milk. No significant differences in mean antibody titer to cow's milk existed between the well, the bottle-fed, and the sudden death groups. Sera with hemagglutinating antibody to cow's milk proteins induced a positive cutaneous anaphylaxis (PCA) reaction, indicating that the measured antibody was probably of the 7S type and capable of provoking the anaphylactic reaction in humans. No evidence was obtained to support the hypothesis that hypersensitivity to milk was causally related to the sudden death syndrome.

PLASTIC INDURATION OF THE PENIS

B. Argren (Rorosherredenes sykehus, Roros, Norway)

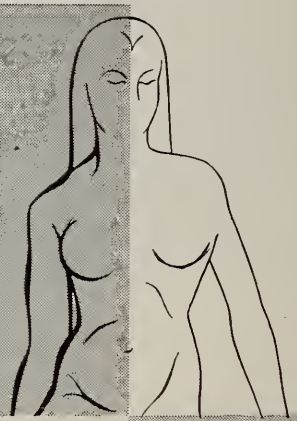
Nord. Med. 71:389 (March 26), 1964.

In commenting on the etiology of plastic induration of the penis, also known as Peyronie's disease, the author mentions, among others, a possible connection with venereal disease, particularly syphilis, and with traumatic factors. A relationship to degenerative collagen diseases is suggested by the observation that, in a considerable percentage of cases, Peyronie's disease concurs with Dupuytren's contracture. After commenting on the incidence, pathological aspects, symptoms, and therapy of plastic induration of the penis, the author presents the case history of a 50-year-old man, who complained of painful erections and difficulties in coitus. He was treated with 15 injections of prednisolone trimethylacetate (Ultracortenol). The painful erections subsided after five or six local injections, and although the induration did not completely disappear, all other symptoms subsided.

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CARCINOMA OF THE BREAST AND PREGNANCY

J. E. Devitt (267 O'Connor St., Ottawa, Ont.), W. G. Beattie, T. G. Stoddart, *Canad. J. Surg.* 7:124 (April), 1964.

Forty-three women were studied in whom breast cancer was associated, in some way, with pregnancy. Seven women with breast cancer treated during pregnancy had survival rates similar to non-pregnant women. Twelve women who first developed the breast mass during a recent pregnancy, but who were treated at some later time, had poor survival rates. Two patients who developed breast cancer during active lactation failed to survive for five years. Twenty-four women became pregnant subsequent to being treated for breast cancer. Such pregnancies, regardless of when they occurred, did not appear to affect adversely the 5- or 10-year survival rates. The significance of these findings is discussed.

STAPHYLOCOCCI IN BRONCHI OF HOSPITAL PATIENTS: AN AUTOPSY STUDY

H. E. Emson (311 Bottomley Ave. N., Saskatoon, Sask.)

Canad. Med. Assoc. J. 90:1005 (April 25), 1964.

Swabs were taken from the main bronchi of hospital patients at routine autopsy, and the cultures were examined for coagulase-positive staphylococci. The proportion of patients yielding positive cultures increased steadily with the length of stay in hospital. There was no correlation between positive cultures and age or sex. The results suggest that bronchi of long-stay patients may form a significant source of dissemination of staphylococci producing "hospital" infections.

ADDICTION TO PLASTER?

A. W. F. Lettin (234 Great Portland St., London)

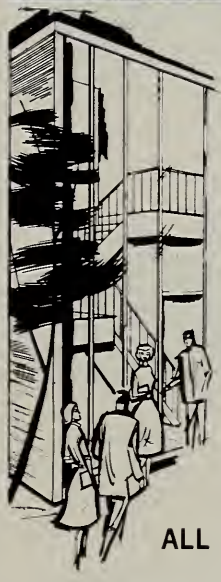
Lancet 1:795 (April 11), 1964.

A 26-year-old woman first complained of backache, for which no cause could be found, in 1934. Immobilization of the spine in a plaster jacket brought some relief, but every time the support was removed the pain returned. The plaster was changed as necessary. In 1951 an attempt was made to substitute a corset, but the patient refused and did not return to the hospital until 1963. She was still wearing the plaster applied 12 years before. She is now completely dependent on the support, and is "addicted" to plaster, like a drug addict addicted to morphine. ◄

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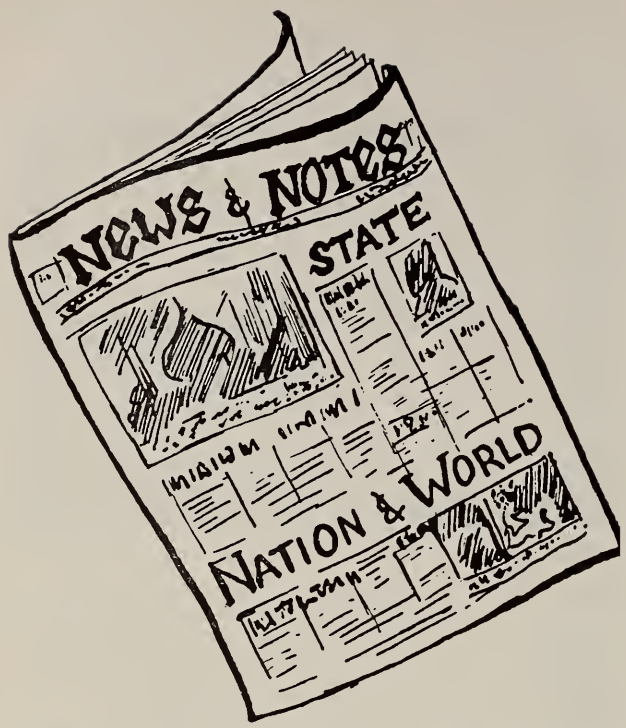
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Dr. Frank B. Ramsey New President of State Medical Journal Advertising Bureau

Frank B. Ramsey, M.D., editor of *The Journal* of the Indiana State Medical Association was elected president of The State Medical Journal Advertising Bureau, Inc. at the July meeting of S.M.J.A.B. held in San Francisco.

Mr. Alfred J. Jackson, who has served as president for so many years has retired, however he will continue to serve the bureau as an adviser.

Mrs. Adelaide K. Davis, Executive Vice-President, will continue her valuable work with S.M.J.A.B.

The Indiana *Journal* and, we are sure, all the other journals that comprise the "group" wish Mr. Jackson a long and pleasant retirement.

I. U. SCHOOL OF MEDICINE ANNOUNCES FACULTY PROMOTIONS

Eleven faculty members at the Indiana University School of Medicine have been promoted to professor, and three have been promoted to clinical professor, effective July 1.

Advanced to professor are Alvin S. Levine, Harold A. Raidt and William A. Summers, microbiology; Morris H. Aprison, psychiatry; William M. Loehr and Hooshang Taybi, radiology; Charles Fisch and Pasquale Genovese, medicine; Byron K. Rust, pediatrics, and J. Neill Garber and Carl D. Martz, orthopedic surgery.

Named clinical professor were Robert Kinzel and Harvey Sigmond, orthopedic surgery, and Donald E. Wood, medicine.

A total of 49 other promotions announced included:

Associate Professor—Evart M. Beck, A. Ebner Blatt, Morris E. Thomas and Helen D. VanVactor, medicine; Thomas Brady, orthopedic surgery; Robert L. Campbell, neurosurgery; Mark L. Dyken, Jr., and Homer B. C. Reed, Jr., neurology; Charles H. Helmen and Rodney R. Million, radiology; B. Louise Irwin and Arlene Wilson, dietetics; Bernard Lubin and Richard E. McCaman, psychiatry; Eugene L. Petry, pediatrics.

Assistant Professor—Paul Benedict, Donald M. Schlegel, Maurice I. Marks, and Harry Siderys, surgery; Robert B. Chevalier, Harvey Feigenbaum, I. E. Michael, Arvin Popplewell, Roland B. Rust, Jr., and Joseph E. Walther, medicine; Sheila D. Dye, dietetics; William L. Franklin, Thomas Horwitz, Robert Palmer and Palmer Eicher, orthopedic surgery; Samuel Giammona, pediatrics; Gerald Groden, neurology; Donald H. Jolly, Toner M. Overley, George Siskind and Carl S. Wright, psychiatry; John Kalsbeck and John Mealey, Jr., neurosurgery; Gerald Kerlander, radiology; William Matthews and Ryland Roesch, anesthesiology.

Instructor—Shokri Radpour, otorhinolaryngology; Edward Schaffer and Frank Throop, orthopedic surgery.

Associate—William Bastnagel, medicine; William B. Call, otolaryngology; Joseph F. Ferrara, Ted L. Grayson and John D. McDougall, surgery.

Indiana Association of Licensed Nursing Homes Elects New Officers

New officers of the Indiana Association of Licensed Nursing Homes have been chosen. Those elected to take office effective January 1, 1965, are as follows: John R. Cooper, Cooper Rest Home, Bluffton, President; Cora Anderson, L.P.N., South View Rest Home, Bluffton, First Vice-President; Ida Miller, Miller Nursing Home, Gary, Second Vice-President; Martha E. Williams, Ben-Hur Home, Crawfordsville, Secretary; Emory H. Vollmer, Vollmer Convalescent Home, Indianapolis, Treasurer; Marjory E. Pearsey, L. P. N., Jackson Nursing Home, Rushville, Governing Council Member to ANHA.

The directors from the various districts are as follows: Robert J. Barna, Roanoke Nursing Home, Roanoke, Northeast District; Pearl Myers, L.P.N., Myers Nursing Home, Bremen, Northwest District; Marybell Frame, Frame Nursing Home, Indianapolis, Central District; Kathleen M. Williams, L.P.N., Williams Nursing Home, Scottsburg, Southeast District; James F. Stocker, Pine Haven Nursing Home, Evansville, Southwest District.

"Health Insurance Trends" Now Available to Physicians

The first edition of a periodical for the medical profession, "Health Insurance Trends," has been published by the Health Insurance Council.

Designed as a report to physicians of progress made by the nation's insurance companies in the financing of health care, the report will be issued bi-monthly by the council.

It will review problems of mutual concern to the medical profession and the health insurance business, with emphasis on areas of joint cooperation. Among the topics to be covered by the new report will be the function and goals of medical society review committees and other programs to conserve the public's health care dollar, as well as simplified claim forms and similar matters of interest to the physician.

"Health Insurance Trends" is being distributed to more than 7,000 physicians, including delegates and alternates to the American Medical Association's House of Delegates, state and county medical society presidents, public relations chairmen and executive secretaries and editors of state and county journals.

The Health Insurance Council, as spokesman for the health insurance business to the providers of health care, is a federation of associations representing insurance companies which issue more than 90% of the health care coverages written by insurance companies.

Dr. Compton Elected President

Dr. Walter A. Compton of Elkhart has been elected president and chief executive officer of Miles Laboratories. He has been executive vice-president since 1961, during which time he participated in the development of research centers in England, Mexico and Elkhart.

Medical Researchers Named To AMA Scientific Advisors Committee

Four eminent medical researchers have been named to the Committee of Scientific Advisors of the AMA Education and Research Foundation to recommend policy for the newly organized Biomedical Research Institute which will start work in 1965.

Those named are Dr. William Hugh Feldman, Washington, D. C., chief of laboratory research in pulmonary diseases for the VA; Dr. Chauncey D. Leake, Department of Pharmacology, University of California; Dr. D. D. Van Slyke, Rockefeller Institute; and Dr. Maurice B. Visscher, University of Minnesota.

Harvey Hallum Retires

Mr. Harvey Hallum, director of professional relations for Mead Johnson Laboratories, is retiring after 30 years service with the company.

Often referred to as "dean of medical representatives," Mr. Hallum started as a sales representative for Mead Johnson in 1934. During World War II he worked in Washington, D. C. as liaison with the war production board.

Non-profit Organization Established To Aid Foreign Travelers Find Doctors

Travel Weekly, a newspaper of the travel industry, announces the formation of a non-profit



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A standard schedule of fees has been adopted and 24-hour service is assured. The IAMAT New York office is at 19 W. 44th St., Suite 1002, New York, N. Y.

Emergency Medical Identification Wallet Cards Available from AMA

Emergency medical identification wallet cards bearing this AMA symbol and with blank spaces for recording of important medical information may be obtained from the AMA at the price of $1.00 per hundred or $5.00 per thousand.



The AMA does not sell bracelets or medallions designed for carrying the same information, but will send a list of organizations which do, if so requested. For cards or information write Emergency Identification—AMA, 535 N. Dearborn St., Chicago, Ill.

SKF Promotes Edward Porter

Edward D. Porter has been promoted to the position of hospital service representative in Indianapolis, for the prescription drug firm of Smith Kline & French Laboratories.

Porter formerly was a senior professional service representative for the firm in Denver, Colorado. He joined Smith Kline & French in 1959. A graduate of DePauw University, Porter is married and has three sons.

PMA Produces Film On Today's Life-Saving Prescription Drugs

A new 15-minute color film which tells the dramatic behind-the-scenes story of today's life-saving prescription drugs has been released by the Pharmaceutical Manufacturers Association.

The 16mm. sound motion picture, entitled "Prescription for Maryanne," is available on a free loan basis for showing to any audience in the United States.

Designed to give an insight into the industry which plays such a vital role in saving lives and relieving human misery, "Rx for Maryanne" tells the pharmaceutical story against the background of a mother's purchase of a prescription for her sick daughter.

Persons wishing to reserve a print should contact E. L. Manke, Modern Talking Picture Service, Inc., 3 East 54th St., New York, N. Y., stipulating the preferred date for showing, an alternate date, and the estimated size of the audience.



ONE OF FIVE Indiana University graduates singled out Sunday, June 7, to receive a distinguished alumni service award was Dr. James O. Ritchey, distinguished service professor emeritus of medicine, Indiana University School of Medicine, Indianapolis. He is shown (right) receiving the congratulations of Dr. Elvis J. Stahr, president of the University. Dr. Ritchey, who maintains an extensive practice, is a former chairman of the Department of Medicine and now serves as chairman of the Medical School's admissions committee.

Indianapolis Dairy Council Expands Services to Surrounding Counties

The Dairy Council of Indianapolis has expanded its services to the eight counties surrounding Marion County.

Nutrition educational materials will be made available to physicians, school personnel, dentists, dietitians and other leaders in the counties of Boone, Hamilton, Hancock, Hendricks, Johnson, Madison, Morgan and Shelby.

S. S. Hope Itinerary Plans Include First Trip to Africa

The hospital ship, S. S. HOPE, now has its itinerary planned for well into 1965. It has been anchored at Guayaquil, Ecuador, for a 40-week stay which terminated September 6. It will put in at Galveston for minor repairs which are expected to take until September 29.

A new permanent staff will join up at Galveston and by October 15 the newly repaired, equipped and staffed hospital and training ship will be at Conakry, Guinea, for its first visit to Africa.

By the time the ship concludes its visit to Ecuador, the staff will have trained nearly 3,000 medi-



THE COUNCIL, sitting in session at the July 19 meeting, was photographed by A. W. Cavins, M.D., Terre Haute, alternate delegate from the Fifth District. Dr. K. O. Neumann, chairman of the Council, is standing in the center of the picture while Drs. Don E. Wood, John M. Paris, Jene R. Bennett and E. T. Edwards sit to his left. Minutes of the meeting are carried on pages 1100-1106 of this month's Journal.

cal personnel in the nations visited, performed over 5,000 major operations and examined and immunized nearly three-quarters of a million people. The mission of the ship is to bring medical teaching and knowledge to the people of newly-emerging nations.

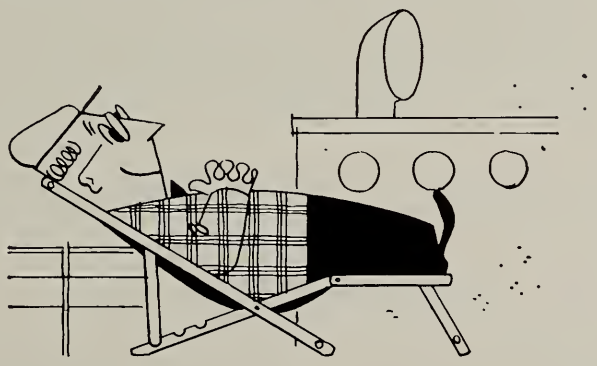
Indiana Physicians Named Diplomates

Six Indiana physicians have been certified recently as Diplomates by the American Board of Pathology.

They are Drs. Wei-Ping Loh and Jack D. Whitaker, Gary; Calvin N. Steussy, New Castle; William J. Pierce, Washington; Avis Jane Lingeman, Brownsburg, and Hsiang Mei Lieu, Munster.

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Indiana Academy of General Practice Moves to New Offices in Riley Center

The Indiana Academy of General Practice has moved into its new offices on the Promenade Level, Tower 3, of the Riley Center, 700 N. Alabama St., Indianapolis.

The academy's new phone number is ME. 6-0781. Charles G. Dosch, Executive Secretary of the academy, invites all Indiana physicians to visit the new offices whenever they have the opportunity.

American Thoracic Society Invites Submission of Papers

The Medical Sessions Committee of the American Thoracic Society invites submission of papers on all scientific aspects of tuberculosis and non-tuberculosis respiratory and cardio-pulmonary diseases for presentation at the 1965 annual meeting in Chicago, May 31-June 2, 1965.

Membership in the society is not a prerequisite to participation in the program. Abstracts of papers should be submitted before January 6, 1965 to the chairman of the medical sessions committee. Further information may be obtained from Benjamin Burrows, M.D., Chairman, Medical Sessions Committee, American Thoracic Society, 1790 Broadway, New York 19, N. Y. ◄

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Annual Meeting Dates of Professional Medical and Allied Organizations

AMERICAN MEDICAL ASSOCIATION CONVENTION
Date June 20-24, 1965
Place New York, N. Y.

AMERICAN COLLEGE OF SURGEONS, INDIANA CHAPTER
Date May, 1965
Place Evansville

BONE AND JOINT CLUB
Date October 14, 1964
Place The Athenaeum, Indianapolis

INDIANA ACADEMY OF GENERAL PRACTICE
Date March 9-11, 1965
Place Murat Temple, Indianapolis

INDIANA STATE SOCIETY OF ANESTHESIOLOGISTS
Date May 15, 1965
Place Indianapolis Athletic Club

INDIANA SOCIETY OF INTERNAL MEDICINE
Date November 22
Place Sheraton-Lincoln Hotel, Indianapolis

INDIANA HOSPITAL ASSOCIATION
Date October 28-29
Place Indianapolis

INDIANA NEUROPSYCHIATRIC ASSOCIATION
Date Second Wednesday of every month, October through May
Place The Athenaeum, Indianapolis

INDIANA STATE MEDICAL ASSOCIATION CONVENTION
Date October 12-15
Place Murat Theater, Indianapolis

INDIANA OBSTETRICAL AND GYNECOLOGICAL SOCIETY
Date November 4
Place Marott Hotel, Indianapolis

INDIANA ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY
Date May 7-8, 1965
Place Oakbrook, Ill.

INDIANA ORTHOPAEDIC SOCIETY
Date May, 1965
Place Indianapolis

INDIANA CHAPTER of the AMERICAN ACADEMY OF PEDIATRICS
Date April 21-22, 1965
Place Marott Hotel, Indianapolis

INDIANA ROENTGEN SOCIETY
Date May, 1965
Place Indianapolis

NORTHERN INDIANA PSYCHIATRIC SOCIETY
Date Fourth Wednesday of every month, September through June
Place For location and program, inquire Beatty Memorial Hospital, Westville



a Private Psychiatric Center at Jacksonville, Illinois, *since 1901*

Complete psychiatric treatment in an environment for cure. A 50 bed hospital with the most modern diagnostic and therapeutic equipment for the treatment of nervous and mental disorders.

LICENSED: Illinois Department of Mental Health.
MEMBER: Illinois Medical Service (Blue Cross-Blue Shield).

"If food makes him feel good, it is not at all surprising that he will turn to it when times are tough, and his tension mounts."[1]



ESKATROL® Trademark

Each capsule contains Dexedrine® (brand of dextroamphetamine sulfate), 15 mg., and Compazine® (brand of prochlorperazine), 7.5 mg., as the maleate.

SPANSULE®

brand of sustained release capsules

controls appetite all day long with a single morning dose

relieves the emotional stress that causes overeating

Brief Summary of Principal Side Effects, Cautions and Contraindications

Side effects (chiefly nervousness and insomnia) are infrequent, and usually mild and transitory.

Cautions: 'Eskatrol' *Spansule* capsules should be used with caution in the presence of severe hypertension, advanced cardiovascular disease, or extreme excitability. There is a possibility, though little likelihood, of blood or liver toxicity or neuromuscular reactions (extrapyramidal symptoms) from the phenothiazine component in 'Eskatrol' *Spansule* capsules.

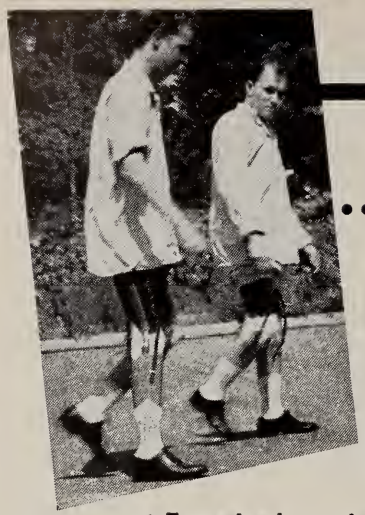
Contraindications: Hyperexcitability, hyperthyroidism.

Before prescribing, see SK&F Product Prescribing Information.

Supplied: Bottles of 50 capsules.

1. Dorfman, W., and Johnson, D.: *Overweight Is Curable*, New York, The Macmillan Company, 1948, p. 16.

Smith Kline & French Laboratories SK&F



...THEY CAN WALK AGAIN

• Torpedoed on the Murmansk run —nearly frozen to death in an open boat—both legs lost below the knee—ex-Merchant Marines Michael McCormick and William Morris walked unaided in three weeks. They could look forward with certainty to leading a normal life again. To these men, as to thousands of other Hanger wearers, the phrase "Hanger is a symbol of help and hope" is a concrete truth proven by every day of their future lives.

Hanger PROSTHESES

1529 N. Illinois St., Indianapolis, Ind. 46202
3108 Burnet Avenue, Cincinnati, Ohio 45229
2521 Fairfield, Fort Wayne, Ind. 46807
416 N. Main St., Evansville, Ind. 47711

The Journal Welcomes New ISMA Members

John C. Baker, M.D., *Insurance Medicine,* University of Nebraska, 1951. (Marion)

John F. Dillon, M.D., *Radiology,* George Washington University, 1947. (Marion)

* John E. Doan, M.D., *General Practice,* Cincinnati University, 1961. (Adams)

Merrill Grayson, M.D., *Ophthalmology,* New York Medical College, 1941. (Marion)

Victor C. Hackney, M.D., *Dermatology,* Yale Medical School, 1943. (Marion)

John B. Mitchell, M.D., *Pediatrics,* University of Texas, 1950. (Vanderburgh)

C. Curtis Smith, M.D., *General Practice,* Indiana University, 1962. (Allen)

* We regret that Dr. Doan's name appeared incorrectly in the August *Journal.*

★

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Professional Protection Exclusively since 1899

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Mailing Address: P.O. Box 20132, Indianapolis 20

Art, Hobby Show Planned For ISMA Indianapolis Meeting

Space will be provided at the 1964 annual meeting of the Indiana State Medi cal Association, Oct. 13-15 at Indianapolis, for a Physicians Art and Hobby Show.

Members of ISMA interested in exhibiting pieces and requiring any information regarding this can contact any one of the following:

Dr. Philip T. Holland
108 W. 7th Street
Bloomington

Dr. Charles P. Schneider
2211 W. Franklin St.
Evansville 12

Dr. Truman E. Caylor
303 S. Main St.
Bluffton

Dr. Frank H. Coble
51 S. Eighth Street
Richmond

Dr. Lall G. Montgomery
Ball Memorial Hospital
Muncie

ISMA Headquarters
3935 N. Meridian
Indianapolis 8

It will be the responsibility of each physician to see that his work gets to the exhibition at the Murat Temple. Final arrangements will be taken care of by Dr. Holland and his committee.

The ISMA will provide suitable display facilities, but each physician is responsible for transportation costs and any other such expense involved in entering his exhibit.

Application for Space in Art and Hobby Show Exhibit

Mail to:

Dr. Philip T. Holland
108 W. 7th Street
Bloomington, Indiana

Name_____

Address_____ City_____

Type and number of pieces to be displayed: Photography_____

Sculpture_____

Crafts_____

Painting_____

Other_____

Estimated amount of space required—lineal or square feet_____

Other information_____

FUTURE MEETINGS, SEMINARS, COURSES

Flying Physicians Association to Hold Annual Meeting in Palm Springs

The Flying Physicians Association will hold its national meeting at the Riviera Hotel in Palm Springs from September 27 through October 2. The scientific program will emphasize safety in the operation of private aircraft.

The association now has over 1,600 members, 90 of whom are practicing physicians in Indiana. Dr. M. F. McGrath of Indianapolis and Dr. Robert Butterfield of Muncie are co-chairmen of the Indiana state chapter.

One of the outstanding attributes of the Flying Physicians Association is the readiness of each individual member to fly anywhere in the continental U. S. to provide medical aid and assistance in the event of a disaster.

Gerontological Society to Hold Annual Meeting October 29-30

The Gerontological Society will hold its 17th annual meeting at the Leamington Hotel in Minneapolis on October 29 to 31.

There will be symposiums on "Endocrines and Aging" and "Transplants and Age," as well as lectures on such subjects as "Effect of Age on Sensitivity to Insulin" and "Recovery after Cerebral Infarction in the Aged" and many others.

The American Academy of General Practice credits 18 hours for the meeting. Registration may be made with Dr. Ernst Simonson, University of Minnesota, Minneapolis 55455.

ESCORT YOURSELF . . .

to Home Lawn Mineral Springs for a few days health vacation —the mineral baths and excellent meals in an atmosphere of serenity will leave your cares behind and play golf on a beautiful course.

HOME LAWN MINERAL SPRINGS

Martinsville, Indiana

M. C. Pitkin, M.D.
Medical Director

J. W. Gibbs, M.D.
Associate Medical Director

AMA Sets Sixth National Conference On Medical Aspects of Sports

The sixth national conference on the Medical Aspects of Sports, sponsored by the American Medical Association, under the auspices of the AMA Committee on the Medical Aspects of Sports, will be held in Miami Beach, Florida, at the Deauville Hotel November 29. The conference will be held in conjunction with the Clinical Convention of the American Medical Association, November 29—December 2.

The conference will cover a wide range of subjects. Included will be papers, panels, and discussions relating to training and conditioning, prevention and treatment of injuries, physiology of sports participation and other subjects.

Those interested in receiving announcements concerning the conference should address the Secretary, Committee on the Medical Aspects of Sports, American Medical Association, 535 N. Dearborn St., Chicago, Illinois 60610.

First National Congress on Strokes Scheduled for October 29-31 in Chicago

The First National Congress on Strokes, designed to stimulate a wide-spectrum program of prevention and management of strokes and rehabilitation of stroke patients, has been scheduled for Oct. 29-31 at the Palmer House in Chicago.

Sponsoring agencies are the American Medical Association, American Heart Association, Heart Disease Control Program of the U. S. Public Health Service and Vocational Rehabilitation Administration of the Department of Health, Education and Welfare.

In announcing the congress, Chairman Frank H. Krusen, M.D., of Temple University School of Medicine, Philadelphia, pointed out that the once hopeless connotation of the word "stroke" can be modified by newly developed concepts and technics in prevention, and by practices developed in the last two decades in rehabilitation.

Annual Scientific Meeting Set For American College of Nutrition

The annual scientific meeting of the American College of Nutrition will be held at the Americana

Continued

)MMEMORATING ITS *90th Anniversary*

F DEDICATED SERVICE IN THE FIELD OF PSYCHIATRY



r almost a century, THE EMERSON A. NORTH)SPITAL, Inc. has been the haven and hope for human ings distraught with nervous and mental disorders d conflicts. Located away from the tensions of the tside world, situated on 40 acres of beautiful private ate grounds—this dedicated hospital offers complete ychiatric treatment and care:

every advancement in the field of psychiatry, proved therapeutic methods and the most modern procedures

services of an active medical staff composed of 20 psychiatrists, augmented by specialist - consultants from the major medical center of Cincinnati

- ample classification facilities and qualified psychiatric nursing
- full recreational therapy facilities
- conveniences and surroundings to assure the greatest comfort and most desirable benefits
- experience and knowledge gained in 90 years of successful operation
- approved by the Joint Commission on Accreditation of Hospitals

PAUL W. WATKINS, M.D.
Medical Director

ELLIOTT OTTE
President

ISABELLE DAULTON, R.N.
Director of Nursing

GRACE SPINDLER, R.N.
Associate Director of Nursing

Brochure and rate schedule available on request

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5642 Hamilton Avenue, Cincinnati, Ohio 45224
Telephones: 541-0135, 541-0136

Oldest private psychiatric hospital west of Alleghenies and largest in state of Ohio



FUTURES

Continued

Hotel in New York City on Sunday, October 25, 1964 at 9 a.m.

For further information, please contact Robert A. Peterman, M.D., Secretary-Treasurer, 3 Craig Ct., Totowa Boro, New Jersey 07512.

"Current Advances in Arthritis" Course Scheduled by Cleveland Clinic

The Cleveland Clinic Educational Foundation will present a course on "Current Advances in Arthritis and Related Diseases" October 7 and 8 at Cleveland.

Further information on the course may be obtained from the Education Secretary, Cleveland Clinic Educational Foundation, 2020 E. 93rd St., Cleveland, Ohio, 44106.

American Ob-Gyn Board Sets Part I Written Examination

The next scheduled Part I (written) examination of this board will be held at various examining centers in the United States, Canada, and military bases outside of the continental United States on Friday, December 11. Candidates eligible to take this examination will be notified on or about November the first where to appear for examination.

Beginning in 1965, the Part I (written) examination will be given early in July. All candidates (including new and reopened applicants as well as re-examinees) having completed an approved and progressive residency program on or before July, 1965 will be eligible to request admission to the Part I examination in 1965.

Bulletins may be obtained by writing to the office of the Secretary, Clyde L. Randall, M.D., American Board of Obstetrics and Gynecology, 100 Meadow Rd., Buffalo, New York 14216.

School Health Problems Conference Will Be October 1 in Valparaiso

A conference on "School Health Problems—Mental and Physical" will be held at Valparaiso University, Valparaiso, October 1.

Principal speaker will be Irving R. Abrams, M.D., Director of Health Services for the Chicago Public Schools.

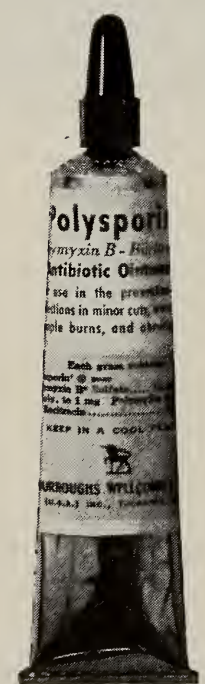
Annual Meeting of Association of U.S. Military Surgeons October 20-22

Modern man's changing living environment — from capsules on the bottom of the sea to capsules floating in space — will draw the attention of the nation's top scientific and medical personnel during the 71st annual meeting of the Association of Military Surgeons of the United States scheduled for October 20 thru 22, 1964 in Washington, D. C. The theme of the meeting is "Military Progress Through Scientific Achievement."

Registration for the meeting, which will be held at the Sheraton-Park Hotel, begins on October 19.

Continued

in treating topical infections, no need to sensitize the patient



USE 'POLYSPORIN'® brand POLYMYXIN B-BACITRACIN ANTIBIOTIC OINTMENT

broad-spectrum antibiotic therapy with minimum risk of sensitization

Caution: As with other antibiotic products, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **Contraindication:** This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.
Supplied: In ½ oz. and 1 oz. tubes
Complete literature available on request from Professional Services Dept. PML.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.



In Sprains, Strains and Muscle Spasm, 'Soma' Compound

numbs the pain...not the patient

A potent analgesic and a superior muscle relaxant

1. A sprain or fracture is not a big clinical problem—but it does hurt. And if there is housework to do and kids to mind, the patient needs something to numb the pain.

2. A.P.C. compounds have limited usefulness; and the patient can buy them without your prescription. Unfortunately, most of them are too mild to be effective for sprains—and more potent products too often make the patient feel 'dopey'.

3. 'Soma' Compound is ideal in these cases. Since it contains both 'Soma' (carisoprodol) and acetophenetidin it is both a potent analgesic and a superior muscle relaxant; it also contains caffeine to offset any drowsiness *("numbs the pain...not the patient")*.

4. Why not try 'Soma' Compound? Dosage is 1 or 2 tablets q.i.d. For more severe pain, try 'Soma' Compound + Codeine. Dosage: 1 or 2 tablets q.i.d.

5. Hypersensitivity to carisoprodol may occur rarely. Codeine may produce addiction, nausea, vomiting, constipation or miosis.

Soma® Compound

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg.

Soma® Compound + Codeine

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning—may be habit forming.)

®WALLACE LABORATORIES / *Cranbury, N.J.*

CSO-9193

FUTURES

Continued

General Chairman of the event is Brigadier General Joe M. Blumberg, MC, USA, Director of the Armed Forces Institute of Pathology in Washington.

Annual dinner reservations for the convention should be made by September 20 with the Association of Military Surgeons of the U.S., 1500 Massachusetts Avenue, N.W., Washington, D. C. 20005.

American Association for Automotive Medicine Will Meet October 26-27

The annual meeting of the American Association for Automotive Medicine will be held this year in Stouffer's Louisville Inn, Monday and Tuesday, October 26 and 27. Sixteen papers in the two-day meeting will cover medical aspects of automotive crash prevention and salvage.

The association was formed in 1957 by a group of physicians interested in reducing the terrific toll of deaths and maiming by motor cars. These men were originally drawn together by experiences as physicians responsible for automotive competition safety.

The American Association for Automotive Medicine is proud of the program offered for this meeting, under sponsorship of the University of Louisville School of Medicine. Scientific sessions will be presented by disciplines, ranging from a chief of police to a general practitioner, from a lawyer to an orthopedist, and from a professor of anatomy to a commissioner of public safety. The quality of participants should lead to many preventive measures resulting in the saving of lives as well as suffering. The automobile manufacturers will "get their lumps" in an exciting, informative and varied program. The University of Louisville Medical School, Department of Surgery, will give a demonstration of its facilities for handling acute trauma cases, as well as offering ward rounds on certain selected cases of trauma.

Symposium on Modern Concepts of Nutrition and Heart Disease Set

A Symposium on Modern Concepts of Nutrition and Heart Disease will be conducted at the Mound Park Hospital Foundation, 701 Sixth Street South, St. Petersburg, Florida October 22 to 24 inclusive.

The fee is $15.00. The American Academy of General Practice allows 18 Category I credit hours.

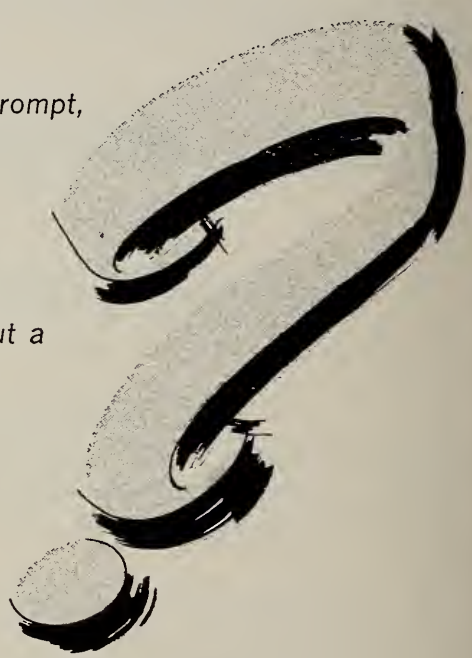
Cleveland Clinic Lists Blood Bank Symposium for October 28 and 29

The Cleveland Clinic will present a postgraduate course on "Blood Banking" October 28 and 29 in Cleveland.

The clinic is presenting the course in conjunction with the Northern Ohio Red Cross Regional Blood

NEVER A QUESTION *about the prompt, dependable service, and the ability to fulfill your every requirement.*

NEVER A QUESTION *about a friendly desire to please — and it's been this way for more than 63 years.*



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35 Modern Laboratories
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W. VIRGINIA • INDIANA • MICHIGAN • ILLINOIS

Center. It will be presented by staff members of the Cleveland Clinic Foundation assisted by guest speakers. Interested physicians should write to the Education Secretary, Cleveland Clinic Educational Foundation, 2020 E. 93rd St., Cleveland 44106.

AEC to Participate in Symposium on Low Energy X-ray and Gamma Radiation

The Atomic Energy Commission, in cooperation with the Illinois Institute of Technology Research Institute, Chicago, will co-sponsor a two-day symposium on industrial and medical applications of low energy x-ray and gamma radiation sources.

The meeting will be held October 20 and 21 in the Illinois Institute of Technology auditorium in Chicago.

During the meeting, government, industry, university faculty and medical speakers will discuss the latest nuclear technologies and uses of beta and gamma-emitting radioisotopes with characteristics and half-lives not commonly available heretofore. New developments in instrumentation and nuclear technics have wide potential application to both industrial and medical problems.

Detailed information on the symposium may be obtained by writing William P. Finnegan, IIT Research Institute, 10 W. 35th St., Chicago 60616.

Gastroenterological Convention Set for October 19, 20 and 21

The 29th annual convention of the American College of Gastroenterology will be held at The Roosevelt in New York City October 19, 20 and 21.

In addition to the several individual papers to be presented, there will be panel discussions on "Gastric Freezing" and on "Benign Diseases of the Esophagus;" symposia on "Gastrointestinal Hemorrhage" and "Gastric Mucosa"; an afternoon of round tables on various subjects and motion pictures. There will again be scientific as well as commercial exhibits and the sessions will be open to all physicians without charge.

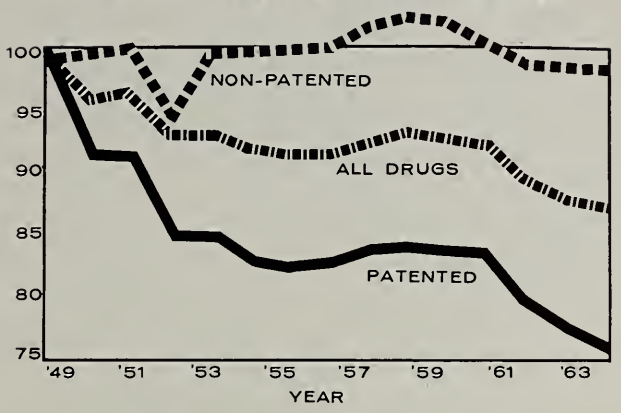
On October 22, 23, 24, immediately following the convention, the annual course in postgraduate gastroenterology will again be given.

Copies of the program and further information may be obtained by writing to American College of Gastroenterology, 33 W. 60th St., New York, N. Y. 10023. ◄

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1. **Contributing $2.00 a week — a small price for your freedom.**
2. **Making your Feelings Known to your Congressman.**
3. **Knowing the Issues.**
4. **Becoming Active in Politics.**

Wholesale Drug Prices Decline



"DRUG PRICES KEEP GOING DOWN, year in and year out, but the public doesn't seem to take notice," Pharmaceutical Manufacturers Association President Dr. Austin Smith said at the PMA's annual meeting. The graph above illustrates the figures he presented to prove his statement. Wholesale prices of all prescription drugs have declined 14% in the 14 years since 1949, and patented products' prices have dropped 24% during the same period. Prices of nonpatented drugs declined two percent during the 14 years. Dr. Smith points out that "If it weren't for the patent system, the incentive for fruitful research and competition it provides, the record suggests the prices for drugs would be higher, not lower than they are." As it is, Dr. Smith notes, a prescription that cost $2.30 in 1949 is available for about $2.00 today. "And today's products, let me remind you, are far superior to those of 1949," the PMA president added.

—Reprinted from Smith Kline & French News, June 19, 1964.

BEFORE LEAVING FOR CONVENTION

at Indianapolis

October, 12, 13, 14 and 15, 1964

Cut this out and give it to your secretary.

TELEPHONE SERVICE:
Registration Desk, Murat Temple—ME. 8-7597
You will be paged immediately.
For those at luncheons or meetings:
Athenaeum number: ME. 5-6336
Columbia Club number: ME. 5-1361.

Leave your secretary a copy of the program with the meetings and luncheons which you will be attending marked so you can be located.

Press and Staff Room
Reception Room off
theater lobby.
Murat Temple, Indianapolis

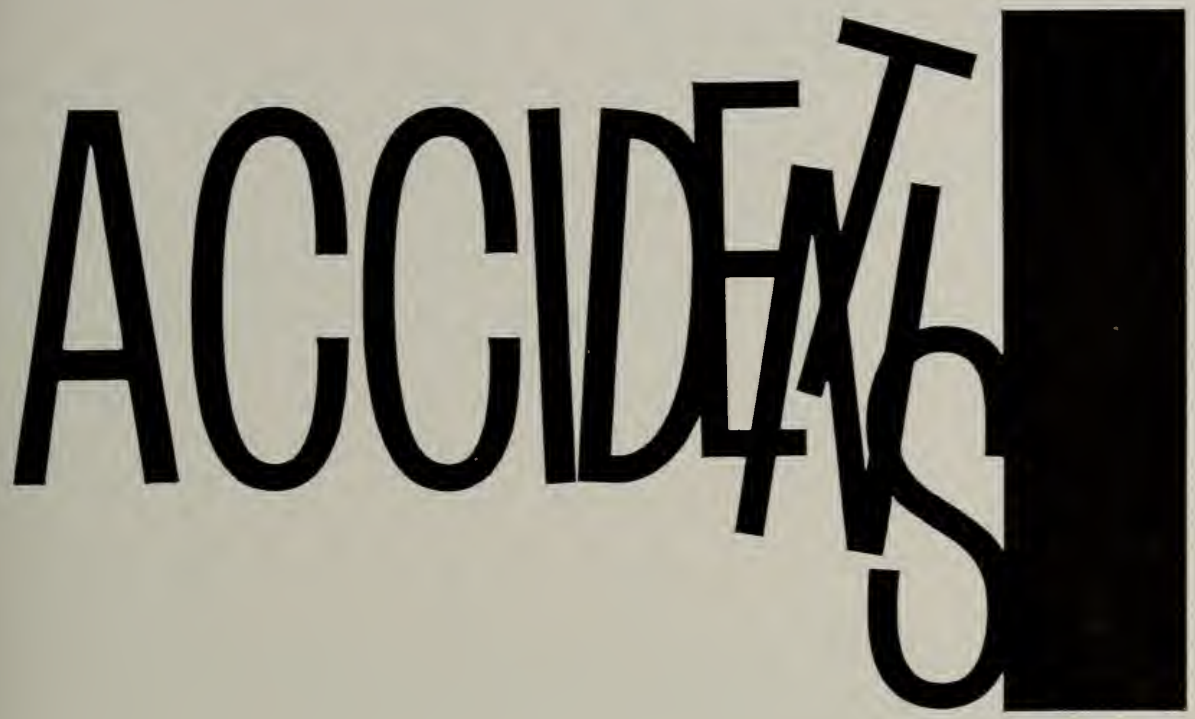


Just turned hypertensive

A 15 mm. Hg drop in diastolic pressure would also suit her very well

For suitably gradual, physiologic hypotensive treatment

(One of a series of ads being used in key Hoosier newspapers)



Can you afford sudden illness or accidents? Today, average hospital charges are about $32 per day in Indiana, and going up. You need a health care plan that provides realistic benefits. You need Blue Cross-Blue Shield, the plan that keeps pace with the advantages of modern medicine as well as its costs. If you know a member who's been ill, ask how Blue Cross-Blue Shield helped out. Odds are they'll say: "I don't know what we'd have done without it."

BLUE CROSS - BLUE SHIELD

MUTUAL HOSPITAL INSURANCE, INC. MUTUAL MEDICAL INSURANCE, INC.

HOME OFFICE: 110 N. ILLINOIS ST., INDIANAPOLIS 9, INDIANA

Deaths

Lawrence M. Hughes, M.D.

Dr. Lawrence M. Hughes, former staff member at Methodist Hospital, died July 10 in New Smyrna Beach, Florida.

A graduate of the I. U. School of Medicine, Dr. Hughes was a past president of the Morgan County Medical Society. At one time he was medical director of the Martinsville Sanatorium and an assistant professor of anatomy at Indiana University.

Paul B. Casebeer, M.D.

Dr. Paul B. Casebeer, 66, of Pompano Beach, Fla., died unexpectedly June 25 in the Charlestown, Ill., hospital.

Dr. Casebeer was born in Hillsdale, Indiana and was a practicing physician in Clinton for many years until he moved to Pompano Beach.

Roger Lingeman, M.D.

Dr. Roger Lingeman, Indianapolis general practitioner, died June 2 at the age of 48.

Graduated from the I. U. School of Medicine in 1943, Dr. Lingeman interned at Methodist Hospital. He was a battalion surgeon and spent two years in the Army, 18 months of which were in Europe. Dr. Lingeman was a member of the Marion County Medical Society.

Aubrey C. Pebworth, M.D.

Dr. Aubrey C. Pebworth, Hendricks County native, died July 3 in a nursing home in South Holland, Ill. He was 86.

Dr. Pebworth, former Pittsboro resident, had practiced medicine in Indianapolis 58 years before he retired in 1963. He began his practice in 1905, after being graduated from the Indianapolis Medical College. He was a member of the 50-Year Club and the Marion County Medical Society. ◄

SCIENTIFIC EXHIBIT APPLICATION FORM

Committee on Scientific Exhibits
Indiana State Medical Association
3935 N. Meridian Street
Indianapolis 8, Indiana

Please send me an application form for a Scientific Exhibit at the ISMA Annual Convention, October 13-15, 1964, Murat Temple, Indianapolis, Indiana.

I propose to exhibit_____

Name_____

Address_____

City_____

State_____

INDIANA STATE BOARD OF HEALTH

MONTHLY REPORT—July, 1964

Disease	July 1964	June 1964	May 1964	July 1963	July 1962
Animal Bites	1304	1139	1068	833	895
Chickenpox	125	203	483	58	84
Conjunctivitis	181	173	142	44	78
Diphtheria	1	0	0	2	0
Dysentery, Unspecified	58	65	45	6	15
Gonorrhea	367	322	325	289	Not Available
Impetigo	252	130	69	78	138
Infectious Hepatitis	46	39	35	25	50
Infectious Mononucleosis	45	58	62	8	8
Influenza	217	120	202	90	197
Measles (Rubeola-Rubella)	548	2358	5019	241	253
Meningitis, Meningococcal	3	2	2	2	0
Meningitis, Other	4	4	7	7	7
Mumps	270	467	751	101	139
Pertussis	79	52	41	102	33
Pneumonia	135	173	200	60	95
Poliomyelitis	1	0	0	0	1
Streptococcal Infections	513	433	468	132	259
Syphilis					
Primary & Secondary	7	5	1	6	Not Available
All Other Syphilis	126	102	98	114	Not Available
Tinea Capitis	6	9	14	2	3
Tuberculosis (Active)	135	90	101	110	100

WABASH VALLEY HOSPITAL

"On the Banks of the Wabash"



A hospital for the treatment of Neuro Psychiatric Disorders

Open Psychiatric and consulting staff

DONALD R. KINZER, Administrator **Lafayette, Indiana Phone Ri. 3-3841**



Your Contributions Are Needed . . .

SUPPORT THESE PROGRAMS OF THE AMA-ERF

- *Funds for Medical Schools* -- Contributions may be designated for one particular school. Undesignated contributions will be distributed equally among all medical schools. No restrictions are placed on the use made of this money by the schools.
- *Loan Guarantee Fund* -- Provides guaranteed loans to medical students, interns and residents. For every dollar in the fund, the private banking industry loans $12.50, at a maximum rate of 6% simple interest.
- *Honors and Scholarship Program* -- Designed to attract students of high promise to careers in medicine—meetings, personal contacts and written materials will be employed. Medical school scholarships will be available to those who need them.
- *Undesignated Contributions* -- Money not designated for any specific AMA-ERF program will be placed in the general fund and the Board of Directors will decide on its use, depending upon need.

AMA-ERF

American Medical Association
Education and Research Foundation
535 North Dearborn Street
Chicago 10, Illinois

ANY PAIN

not severe enough to require morphine is an indication for

'Empirin'® Compound with Codeine



'EMPIRIN' COMPOUND with CODEINE No. 3
KEEPS THE PROMISE OF PAIN RELIEF

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

Association News

EXECUTIVE COMMITTEE

July 18, 1964

Present: G. O. Larson, M.D.; Don E. Wood, M.D.; Joe M. Black, M.D.; Kenneth O. Neumann, M.D.; Irvin W. Wilkens, M.D.; Ottis N. Olvey, M.D.

Frank B. Ramsey, M.D., editor of *The Journal;* Robert Hollowell, attorney, and James A. Waggener, executive secretary.

In the absence of the chairman Dr. Wood took the chair to conduct the meeting of the Executive Committee.

Headquarters Office

By motion, taken by consent, the association will offer a post AMA tour to the Virgin Islands and Puerto Rico.

Building Matters

Action on the proposal of the Wil-Ten Co., Inc. concerning the exit on Fortieth Street in exchange for use of a portion of the parking lot was deferred until Dr. Everly returns.

Treasurer's Office

The treasurer's report and balances as of June 30 were accepted by consent.

Annual Convention, Indianapolis, October 13, 14 and 15, 1964

The guest list for the president's luncheon was reviewed and by consent it was agreed that the same individuals should be invited as has been the custom in the past when a banquet was held.

A letter from Clowes Memorial Hall concerning the association buying the house for the night of October 14 as an entertainment program was read, and on motion of Drs. Neumann and Olvey the offer was turned down.

The secretary reported on the sale of exhibit space for the 1964 meeting.

Legislation - National

Comments made by Senator Bayh in a letter to the Indiana State Dental Association were read for the information of the committee.

Organization Matters

Request of the Commission on Medical Education to send a representative to Albany, New York, to review the postgraduate program conducted by the school there was turned down for the present time, on motion of Drs. Wilkens and Neumann.

Request of the Indiana Division of the American Cancer Society for the association to permit the use of its name as a co-sponsor for the annual symposium of the Cancer Society, to be given at the Indiana University School of Medicine on September 23, was approved by consent.

Request of the University of Louisville to use the association mailing list to notify Indiana physicians of the 4th annual postgraduate course in Anesthesiology was approved on motion of Drs. Neumann and Larson.

A letter from the Chicago Committee for Project Hope requesting the use of the mailing list and asking the association to make an appeal to its membership for contributions to the cause was turned down on motion of Drs. Larson and Neumann.

The secretary gave a further report on the efforts of the association to increase fees of the Veterans Hometown Fee Schedule.

A letter from the White House concerning a regional conference on physical fitness, to be held at the University of Illinois on October 16 and 17, 1964, was reviewed, as was correspondence from other states concerning their attitude toward cosponsoring this program. Upon motion, taken by consent, the secretary was instructed to advise the White House that the association would be willing to cooperate in this program but it will not cosponsor it.

A letter from the Department of Health, Education and Welfare concerning a survey to be made of children in Lake county was read, and the secretary's reply to the department advising them to seek approval of the Lake County Medical Society was approved by consent.

The secretary read a letter from Dr. J. S. Reese of Martinsville which he had referred to the Commission on Public Health. He also read the action taken by the Commission on Public Health, for the information of the committee.

Appropriate documents to close out the Medicare contract for the year ending March 31, 1964, were reviewed and the president was authorized to sign on behalf of the association.

Request of the Health and Hospital Corporation of Marion County for use of the mailing list of the association to notify physicians of the postgraduate courses to be offered during the 1964-65 academic year was approved on motion of Drs. Neumann and Larson.

A letter from the State Board of Health concerning the Governor's Rehabilitation Awards was reviewed and this was referred to the Commission on Public Health.

A copy of a letter addressed to Dr. Glen V. Ryan by Dr. John Beeler was read for the information of the committee and upon motion of Drs. Wilkens and Neumann a copy of this is to be referred to the Council Liaison Committee with Blue Shield.

A letter from Dr. Offutt to the president concerning the establishment of a committee to review the medical aspects of driver licensure was reviewed and by consent it was agreed that the association should cooperate with Dr. Offutt and the Governor, the president to name the members of the committee.

A letter from Dr. N. L. Salon concerning a replacement on his committee to represent the association on the Joint Council on Aging was reviewed, as was the secretary's recommendation that Dr. Salon select a member of his commission to

fill this vacancy, and this action was approved by consent.

A copy of a resolution adopted by the Indiana State Dental Association, tentatively approving of Blue Shield offering a dental plan, was read for the information of the committee.

An announcement of the plans of Indiana University to conduct a clinic on athletic injuries was reviewed and the action which had been taken was reported by the president-elect.

New Business

A letter from Mrs. Alice Cooper, executive secretary of the Indiana Lions Eye Bank, Inc., notifying the association that the terms of Dr. Max Bartley and Dr. Marvin Cuthbert had expired and requesting the association to name representatives to this organization was reviewed and upon motion of Drs. Neumann and Larson it is to be recommended that Drs. Bartley and Cuthbert be reappointed.

The Journal

The editor of *The Journal* reported on the reorganization of the State Medical Journal Advertising Bureau and reviewed the billing by the bureau which is showing a slight increase over a year ago.

A resolution from the Oklahoma State Medical Association directed to the pharmaceutical industry concerning its placement of advertising in state medical journals was read for the information of the committee.

The report which had been prepared by the editor of *The Journal* and the business manager for submission to the Council Business Management Committee was reviewed for the information of the committee.

Medical Defense and Legal Matters

A letter complaining about the Indiana Institute of Medical Assistants was ordered referred to the Marion County Medical Society.

Future Meetings

District Society meetings. The following were assigned to represent the association at these meetings:

District 5—Brazil, September 16, 1964—Dr. Black

District 10—Whiting, September 16, 1964—Dr. Larson

District 11—Wabash, September 16, 1964—Dr. Neumann

District 13—Michigan City, September 16, 1964

AMA Regional Conference on Disaster Medical Care, Louisville, July 25-26. Dr. Jean V. Carter was authorized to represent the association.

AMA Public Relations Institute, Chicago, August 20-21, 1964. The chairmen of the Commissions on Public Information and Legislation are to attend, together with the officers and the staff of the association.

AMA National Conference on Health Education Goals, Chicago, October 30-31. This is to be discussed at the next meeting of the Executive Committee.

AMA Second National Congress on Mental Health, Chicago, November 5-7. The AMA is to be authorized to invite the same people as were invited two years ago.

Request of the AMA for the executive secretary to serve as a participant in the workshop group was approved by consent.

National Conference on Medical Aspects of Driver Safety and Driver Licensing, Chicago, November 16-18. Approval was given for one of the members of the committee, to be appointed by the president, to attend this meeting.

Sixth National Conference on Medical Aspects of Sports, to be held on Sunday, November 29, Miami Beach, preceding AMA Clinical Session.

AMA Clinical Session, Miami Beach, November 29 to December 2.

Public Affairs Conference, Washington, D.C., February 3-4, 1965. The question arose as to whether the Executive Committee should make its annual visitation to Washington during this conference or during the United States Chamber of Commerce annual meeting and it was agreed that this should be discussed further at the next Executive Committee meeting.

The request of the Commission on Public Health to send a representative to Houston, Texas, September 26, 27 and 28, at which time the Congress on Occupational Health will meet concurrently with the Texas Medical Association, was reviewed. Inasmuch as Dr. Durward Paris of Kokomo is chairman of the Scientific Work Committee in Indiana for 1965, at which time the occupational health group will meet with the Indiana State Medical Association, it was felt that he would be the proper individual to send to this meeting. This was approved on motion of Drs. Black and Wilkens.

There being no further business the committee adjourned to meet again upon the call of the chairman. ◄

THE COUNCIL

The Council of the Indiana State Medical Association convened for its summer meeting at 10:00 a.m., Sunday, July 19, 1964, in the headquarters building, 3935 North Meridian Street, Indianapolis, with Dr. Kenneth O. Neumann, chairman, presiding.

Roll call showed the following present:

Councilors:

First District—Not represented
Second District—E. T. Edwards, Vincennes
Third District—John M. Paris, New Albany (also AMA alternate delegate)
Donald M. Kerr, Bedford, alternate, and councilor-elect
Fourth District—Jack E. Shields, Brownstown, alternate councilor (also AMA delegate)
Fifth District—V. Earle Wiseman, Greencastle
A. W. Cavins, Terre Haute, alternate
Sixth District—William R. Tindall, Shelbyville
Seventh District—Albert M. Donato, Indianapolis
Charles A. Jones, Franklin, alternate
Eighth District—Donald R. Taylor, Muncie
Ninth District—Kenneth O. Neumann, Lafayette
Peter R. Petrich, Attica, councilor-elect
Tenth District—Lowell H. Steen, Whiting
Eleventh District—E. S. Rifner, Van Buren
Lowell J. Hillis, Logansport, alternate
Twelfth District—Milton F. Popp, Fort Wayne
William R. Clark, Fort Wayne, alternate
Thirteenth District—Jene R. Bennett, South Bend

Officers:

Don E. Wood, Indianapolis, president
Joe M. Black, Seymour, president-elect
Irvin W. Wilkens, Indianapolis, treasurer
Ottis N. Olvey, Indianapolis, assistant treasurer

Journal:

Frank B. Ramsey, Indianapolis, editor

Executive Committee:

G. O. Larson, LaPorte, member

Guests:

Harold C. Ochsner, Indianapolis, AMA delegate
Guy A. Owsley, Hartford City, AMA delegate
William B. Challman, Mount Vernon, AMA alternate delegate
A. C. Offutt, Indianapolis, State Health Commissioner
Lester D. Bibler, AMA Trustee, and chairman. Student Loan
D. S. Megenhardt, Indianapolis, Professional Advisory Committee, Blue Cross
Lowell I. Thomas, Indianapolis, chairman, Ad Hoc Committee, Indiana Hospital Association
Dwight W. Schuster, Indianapolis, vice-chairman, Commission on Legislation
John W. Beeler, Indianapolis, member, Commission on Medical Economics and Insurance
Arthur G. Loftin, Indianapolis, executive secretary, Marion County Medical Society

Staff:

Ralph Hamill, attorney
Robert J. Amick, field secretary
Howard Grindstaff, field secretary
K. W. Bush, administrative assistant
J. A. Waggener, executive secretary

On motion of Drs. Steen and Popp, minutes of the meeting held April 26, 1964, were approved as printed in the July, 1964 *Journal*.

The chairman announced that word had been received of the death of Dr. Harry Ross, of Richmond, on July 18, 1964. Dr. Ross served as councilor (from November 12, 1954 through 1961) and devoted many hours to the work and activities of the state medical association. The Council stood in silence for a moment in memory of Dr. Ross. The secretary was instructed to send a letter of condolence from the Council to Dr. Ross' family.

Reports of Councilors

DR. PARIS, Third District, announced that Dr. Donald M. Kerr, of Bedford, who has served as alternate councilor for the past three years, has been elected councilor of the Third District, his term to begin October 16, 1964. Dr. E. L. Wallace, New Albany, was elected alternate councilor to fill the unexpired term of Dr. Kerr.

DR. NEUMANN, Ninth District, announced that Dr. Peter Petrich, of Attica, had been elected councilor to succeed him at the expiration of his term in October. Dr. Albert E. Stouder, of Kempton, continues as alternate councilor.

DR. STEEN, Tenth District, reported that 1965 meeting dates had been set for his district, as follows: May 12, 1965, in Gary; October 13, 1965, in Whiting.

DR. RIFNER, Eleventh District, announced that his district would meet September 16, 1964, at Wabash.

DR. POPP, Twelfth District, reported on the May, 1964, meeting in his district and announced that next year's meeting would be held at Fort Wayne on May 19, 1965.

Unfinished Business

1. *Plan for Total Medical Care*, tabled at the April 26, 1964, Council meeting, was removed from the table on motion of Drs. Paris and Popp.

On motion of Drs. Paris and Popp, the Council voted not to consider this plan for total medical care as "it is at variance with the attitude of the American Medical Association, the attitude of the Indiana State Medical Association, and, I believe, the attitude of almost every doctor in the private practice of medicine. The idea of nationalizing the hospitals of the United States of America is foreign to all of us." (Dr. Paris).

2. *The matter of billing members for I-HOPE* at the same time dues statements are sent out, tabled at the April 26, 1964 Council meeting, was removed from the table by consent. Discussed by Judge Hamill and Dr. Black. As advised by the legal counsel, **on motion of Drs. Rifner and Donato, the Council voted that billing members for I-HOPE**

at the same time dues statements are mailed should not be done.

3. *Nomination of Council liaison representative* of the Indiana State Medical Association to sit with the Board of Directors and Medical Advisory Committee of Blue Cross was discussed by Drs. Popp, Edwards and Rifner. Dr. Paris nominated Dr. Donato; seconded by Dr. Steen. Because of the press of other obligations, Dr. Donato declined the nomination and Drs. Paris and Steen withdrew their nomination. **By consent this matter was deferred until the October Council meeting.**

4. *Areawide Planning of Facilities for Rehabilitation Services.* Dr. Offutt's report on "Areawide Planning of Facilities for Rehabilitation Services," presented to the Council by the Commission on Public Health and approved by the Commission on Public Health at its meeting on January 19, 1964, **was approved by the Council on motion of Drs. Popp and Edwards.**

5. *Transfer of payment of fees for radiology and pathology services from Blue Cross to Blue Shield.* A letter from the Indiana Association of Pathologists saying that a recent poll of its membership showed that an overwhelming number of pathologists favor the transfer of payment for their services from Blue Cross to Blue Shield was reviewed for the information of the Council.

Letter from the association's legal counsel regarding costs of litigation, the action of the AMA House of Delegates at the June, 1964, meeting in San Francisco, and a letter from the Indiana Roentgen Society stating that that society had voted unanimously for the transfer of benefits from Blue Cross to Blue Shield, were also reviewed.

These matters were to be discussed later in the meeting following a report from Dr. Lowell Thomas, chairman of the Ad Hoc Committee on Blue Cross-Blue Shield Transfer.

Matters Referred to Council by Executive Committee

DR. WOOD, in the absence of Dr. Ralph V. Everly, chairman of the Executive Committee, reported that the Executive Committee had discussed the matter of developing a policy concerning podiatrists' relationship to hospital privileges, and the committee had referred this problem to the Commission on Medical Education and Licensure. The Executive Committee feels that this is a matter to which the Council should be giving some thought.

Dr. Paris commented that "It might be of interest to the Council to know that the Indiana Blue Shield has appealed the verdict of the lower court, which held for the Insurance Commissioner the fact that Indiana Blue Shield is responsible for paying podiatry and other allied medical peoples."

Reports of Officers

DR. DONALD E. WOOD, president, reported that during the past few months he had attended the Ohio, Illinois and Wisconsin State Medical Associations' annual conventions, which had proved a very interesting experience. "Our organization does a remarkably good job, but I think one field in which we might improve our efforts is in that of public relations These other states do more in this field than we do here in Indiana."

Dr. Wood complimented the AMA delegation for the good job it is doing for the Indiana State Medical Association.

As a member of the AMA Council on Legislative Activities, Dr. Wood discussed the proposed changes in the Social Security program and the present status of the King-Anderson bill.

Relative to creating better public relations, Dr. Wood spoke of the proposal, to be discussed with the Council later in the meeting, of awarding appropriate certificates or plaques of merit to: (1) an individual who makes an outstanding contribution to the medical profession in caring for people in case of a catastrophe; (2) a press individual, or an individual in public life who has made an outstanding contribution in the field of medicine, which medicine should recognize; and (3) an individual in medicine who has made outstanding contributions in the field of medicine, medical organization, and medical education.

DR. JOE M. BLACK, president-elect, reported that Dr. Robert Reid, Columbus, had been elected Fourth District councilor (to fill Dr. Black's unexpired term ending October, 1965) and that Dr. Jack Shields, Brownstown, had been elected alternate councilor, his term to end in 1967.

Dr. Black also spoke of the effectiveness of the Indiana delegation at the AMA meeting at San Francisco.

Dr. Black discussed the importance of implementing the TB eradication program and asked that the councilors take this message back to their districts.

Dr. Black reported that he had discussed with the State Board of Medical Registration and Examination some of the problems of the board. He stressed the importance of better liaison with the board members, and the creation of better public relations, with an end to increasing the number of physicians in the state. "As far as the state institutions are concerned, this is an emergency, and a problem about which the Council should think very seriously." (The Medical Practice Act was also discussed by Drs. Owsley, Shields, Steen and Edwards. Dr. Shields suggested that a liaison committee be appointed to look into this matter.)

Dr. Black also discussed the conference held by Indiana University on athletic injuries. As a result of this discussion, it was suggested that the state association again participate in the coaches' conference which is held during the state teachers' meeting in October, and which is sponsored by the Marion County Medical Society. One Council member commented, "With all these coaches here for this meeting, if the state association, in conjunction with Marion County, would put on a panel and a day's program on athletic injuries and athletic examinations, it would be a tremendous public relations program."

DR. IRVIN W. WILKENS, treasurer, presented statements showing the assets and liabilities and the balances in the various funds of the Association. "Cash balance in the General Fund as of June 30, 1964, is $26,868.11, $21,204.50 of which is theoretically not usable until October 1. This leaves us with a balance of $5,663.55 available for operation between now and October 1. At this point some consideration must be given to obtaining funds for operation during the last quarter of the current fiscal year."

Dr. Wilkens, in explaining the financial status of the association, said that it looks as if some consideration would have to be given to increasing the membership dues. (This was to be discussed later in the meeting with the chairman of the Student Loan Committee.)

DR. FRANK B. RAMSEY, editor of *The Journal*, reported on the increase in advertising within the past few months, and that *The Journal* revenue is running about 25% above the amount budgeted.

Dr. Ramsey also reported that he represented the officers of the ISMA at the First District Society meeting in May, in Evansville.

"The State Journal Advertising Bureau is now in the process of being reorganized. As you know, I am a member of the board of directors We have a policy committee that has been studying the operation of the bureau for the last nine months. The committee's main recommendation is that all the activities of the bureau be directed more toward selling. We are now in the process of employing a top-notch salesman. Mr. Jackson, who was retired the first of July, was primarily an administrator, and the bureau has always been an administrative organization. Mr. Jackson was president of the bureau and the chief executive officer. The committee thought, and our advertising consultant thought, that it would be a good thing to elect one of the directors as president of the bureau, to get an M.D. on the letterhead. Since I live close to Chicago, I have been selected as president of the bureau. I probably will have to spend some time in Chicago in relation to that, and we look forward to improving the advertising on a national level. Later we shall have recommendations for each journal, and each of the 34 associations which belong to the journal bureau as to actions that each can take to improve business."

In the absence of Dr. Corcoran, chairman of the Committee of Business Consultants for *The Journal*, Dr. Ramsey reported on the cost of producing the roster issue of *The Journal*, and stated that the cost was lower this year than at any time in the last four years, and next year it probably will be still lower.

Dr. Ramsey recommended that the association establish an endowment fund, or an educational trust, to which physicians and others could contribute funds either in their lifetime or in their wills, the income from which could be used in publishing *The Journal*. "I would like to recommend that the Council explore further with our legal counsel the requirements for establishing such a fund." **On motion of Drs. Edwards and Popp, the Council voted to authorize the legal counsel to draw up a document which would permit the setting aside of funds for the state *Journal*."**

Report of AMA Delegates. Actions taken at the San Francisco meeting, June 21 to 25, 1964, were amplified by Dr. Ochsner, speaking on (1) the tobacco and health problem, and (2) the proposed increase in AMA dues, which was referred to the Board of Trustees for study and report at the 1964 Clinical meeting in Miami; Dr. Owsley reporting on the human rights issue, and Dr. Paris discussing actions of the Reference Committee on Insurance and Medical Services.

DR. LESTER D. BIBLER, member of the AMA Board of Trustees, discussed actions taken by the Board of Trustees at the San Francisco meeting, among which were: (1) approval of professional liability coverage for interns and residents, money for this purpose to be loaned from AMA-ERF; (2) accreditation of nursing homes; (3) request of the Woman's Medical Association for financial assistance, which was referred to the AMA-ERF without recommendation; (4) increase in dues; (5) use of Dr. Annis' services for at least the next six months; (6) better liaison between physicians and their medical assistants, and (7) elections to the Board of Trustees. (For complete report, see pages 906-911, August, 1964, *Journal*.)

Economic and Organization Matters

1. *Remission of state dues.* **On motion of Drs. Donato and Paris the Council voted remission of state dues for 1965 of a member of the Marion County Medical Society** because of removal from Indiana and retirement from practice.

2. *Trust Committee of Indiana Medical Education Foundation.* **On motion of Drs. Donato and Paris, Drs. James W. Denny, Indianapolis, and Loren H. Martin, Indianapolis, were elected to succeed themselves as members of the Trust Committee of the Indiana Medical Education Foundation for the three-year term ending October 31, 1967.** Membership of this committee for the ensuing three years is as follows:

	Term Expires
Maurice V. Kahler, Indianapolis	October 31, 1965
Lawson J. Clark, Indianapolis	October 31, 1965
Don E. Wood, Indianapolis	October 31, 1966
Roy Geider, Indianapolis	October 31, 1966
James W. Denny, Indianapolis	October 31, 1967
Loren H. Martin, Indianapolis	October 31, 1967

New Business

1. *Awards by the Association.* Dr. Wood elaborated on the suggestion which he had made earlier in the meeting that awards of merit be given by the association in recognition of outstanding accomplishments by certain individuals, saying that he would like to have this matter assigned to the appropriate commission for implementation for the Council.

On motion duly made, seconded by Dr. Popp, the Council assigned this task to the chairman of the Council, to be implemented by the time of the state meeting.

2. At the suggestion of Dr. Steen, by consent the Council authorized the recognition of Dr. Ralph Eades, who is ill, for his long service to the Council and the state medical association. This recognition is to be in the form of a resolution, signed by the officers of the association, or a plaque. The secretary was asked to take care of this matter.

3. DR. SHIELDS, president of I. U. Alumni Association, reported on the successful meeting of the alumni association held during the AMA meeting at San Francisco, and urged the members of the Council to attend these meetings in the future.

Matters from Committees and Commissions

1. *Student Loan Committee.* DR. LESTER D. BIBLER, chairman, reported that at a meeting of his committee held just prior to this Council meeting, the committee had discussed the financial statement of the Student Loan Fund and as a result had adopted two resolutions for the consideration of the Council:

(1) BE IT RESOLVED that this committee authorize the loan of $10,000.00 from cash on hand to the General Fund of the Indiana State Medical Association, without interest, to be repaid January 1, 1965.

This resolution was adopted by the Council on motion of Drs. Bennett and Donato.

(2) WHEREAS this committee has on deposit with the Indiana National Bank $20,810.00 to guarantee loans to students under the new program and will receive repayment of the $10,000.00 loan from the General Fund January 1, 1965;

That in addition there are approximately $29,000.00 of accounts receivable in the form of outstanding loans made under the old program which can be added to the guaranteed fund which will make it sufficient to guarantee over one-half million dollars in loans, and

WHEREAS there have only been 14 loans totaling $8,300.00 guaranteed loans made under the new program and an additional $1,300.00 in process,

It appears that the $5.00 which will be received from the 1964 dues will not be needed for the guaranteed fund this year,

BE IT RESOLVED that it be suggested to the Council that it give consideration to submitting a resolution to the House of Delegates that the 50% of the $10.00 in 1964 dues structure be allocated to the General Fund.

This resolution was discussed by Drs. Rifner, Ochsner, Paris, Wood and Edwards. **By consent, the Council instructed the Student Loan Committee, in conjunction with the Executive Committee, to present this matter to the House of Delegates in its annual report to the House.**

Dr. Steen's motion "that the Student Loan Committee be instructed to bring to the Council some information regarding their vast performance, their future anticipated needs, and so forth, with regard to funds so that at some future date, not later than the end of this year, we may set a ceiling on what the ultimate total amount of cash should be in the Student Loan Fund" was taken by consent.

The chairman suggested that at the same time this report is made, the legal counsel should be asked to look into the original agreement under which the Student Loan Fund was established, to determine whether or not the $40,000.00 originally appropriated to this fund by the House of Delegates is to revert back to the General Fund.

2. *Council Liaison Committee with Blue Shield.* Dr. Steen, chairman, reported that his committee had met with the Blue Shield Liaison Committee and Dr. Glen Ryan on July 12, 1964, and had discussed the following matters:

(1) More adequate identification on statements of premium coverage for Blue Cross and Blue Shield so that it is readily apparent that a statement is a combined statement for Blue Cross and Blue Shield premiums. (Dr. Neumann informed the committee that this matter had been brought to the attention of the Blue Cross liaison committee at a meeting one week previously and would be rectified. Dr. Ryan is in agreement with this, and this was presented to the board of directors at their meeting on July 12, 1964.)

(2) Relationship between the state medical association, the Blue Shield Board, and the officers of Blue Shield. Dr. Steen said liaison between these groups has improved in the past year; the chairman of the Council liaison committee has been completely apprised of important activities by means of copies of letters from various Blue Shield officers, and he has been invited to and attends the Blue Shield executive committee meetings. Dr. Glen Ryan, president of Blue Shield consults with the officers of the state association, or with the Council liaison committee on all policy decisions.

(3) Communication to Dr. Ryan from Dr. Edward Edwards, on which the Council liaison committee made certain comments and recommendations to the Blue Shield board.

Dr. Edwards and many of the Council members discussed the need that exists for the Council to define the function or the role of the physician members of the Blue Shield Board. **The motion made by Drs. Edwards and Bennett, and discussed by many "that the Commission on Medical Economics be instructed to study, to evaluate, and to make recommendations concerning the role of the physician members on the Blue Shield board" was put to vote, and carried.**

3. *Blue Shield Board of Directors.* Dr. Challman, in the absence of Dr. Corcoran, reported that Dr. George W. Willison had been re-elected to the

Blue Shield Board of Directors at the First District society meeting in May.

4. *Commission on Legislation.* DR. DWIGHT SCHUSTER, vice-chairman of the Commission on Legislation, outlined the legislative issues being studied and considered by the commission, as follows: confidentiality of privileged information; the abused child problem; therapeutic abortion legislation; chiropractic efforts regarding compensation under Workman's Compensation laws; role of podiatrist under Kerr-Mills; Indiana physician shortage and its relationship with licensure in Indiana.

Dr. Schuster also spoke on and asked approval of and support for the formation of a Speakers' Bureau with a speakers' training course, possibly in conjunction with the Woman's Auxiliary. Such a bureau would serve not only a legislative need, but it would be an excellent public relations element. No action was taken.

Additional issues being studied, on which the Commission on Legislation suggests that the membership of ISMA, through the Council and the House of Delegates, formulate or reiterate the policies for the commission's direction, are: (1) new medical school with reference to legislative action; (2) changes in present school with reference to legislative action; (3) Kerr-Mills implementation or changes; (4) implementation, or participation in the Community Mental Health Services; (5) voluntary (HR 515) or compulsory (HR 3122) Social Security for physicians.

5. *Council Ad Hoc Committee with Indiana Hospital Association.* DR. LOWELL I. THOMAS, chairman, read the following report:

Since our committee's report of April 26, 1964 the questions raised in our letter of April 24, 1964 have been submitted to the legal counsel for the ISMA, Ralph Hamill. His reply of June 2, 1964 is in today's agenda folder.

It is set forth in his report that under Indiana law the practices of radiology and pathology are in the practice of medicine.

It is also set forth that hospitals cannot practice medicine. One must then recognize that Mutual Hospital Insurance (Blue Cross) cannot contract with patients to furnish medical services of any kind through hospitals. This should be done through Mutual Medical Insurance (Blue Shield) agreeing to indemnify members for professional services performed by physicians.

With these facts in mind, it is assumed that Blue Cross and Blue Shield must rewrite their contracts in compliance with the law of Indiana, transferring these payments for professional services from Blue Cross to Blue Shield.

Concurrently, we assume, hospitals in Indiana must cease billing patients for services which they are not licensed to render, and physicians practicing these specialties in hospitals must find ways individually or in conjunction with the hospitals, to charge patients for the professional services they provide. It is to be expected that contracts between physicians and hospitals will follow the guiding principles laid down in the *AMA Report on Physician—Hospital Relations.*

We should also be mindful in accomplishing the transfer from Blue Cross to Blue Shield that the mechanisms and the costs of administration be maintained in an economical and efficient manner.

This committee recognizes the undesirable aspects of entering into any legal action to force the above outlined issues, yet we wonder whether this matter is one which should be negotiated between the presently interested parties alone. We feel that the answers to the two following questions may provide the means to resolve our problem:

(1) Is there some state administrative body which would require compliance if we point out what we believe to be the improper nature of present Blue Cross contracts, and the present Blue Cross Articles of Incorporation?

(2) Is there some way short of a court action whereby we can determine how the law would finally be interpreted?

The subject of transfer of fees was discussed fully by Drs. Rifner, Steen, Bennett, Paris, Beeler, Wood and Edwards and Judge Hamill, following which **the motion of Drs. Steen and Edwards "that the Council authorize proceeding with these proceedings (as outlined by Judge Hamill in his letter of June 2, 1964) at maximum possible haste" was put to vote, and carried unanimously.**

6. *Recommendation of Commission on Aging* that medical students be exposed at least once a year to a lecture on gerontology **was approved on motion of Drs. Shields and Tindall.**

7. *Recommendations of Commission on Constitution and Bylaws* concerning introduction of resolutions in the House of Delegates and filing of county society constitutions and bylaws in the headquarters office **were approved by consent.** These recommendations are:

(1) *On resolutions.* The Commission on Constitution and Bylaws recommends to the Council that the Council officially notify all county medical societies as follows: "Any resolution which is to be presented to the House of Delegates, and not reaching the headquarters office within the 45 day limit, as provided in Chapter IV of the Bylaws, shall first be submitted to the Committee on Rules and Order of Business of the House to determine if the resolution is of such an emergency nature that it cannot be held over until the next meeting of the House, and that the proponents of the resolution in addition to supplying ample copies of the resolution, shall in writing set forth the reasons why this resolution was not made available to the delegates prior to coming to the meeting of the House of Delegates and setting forth why the delegate or his society considers this of such an emergency nature that it cannot wait until the next meeting of the House."

(2) *On filing county society constitutions and bylaws.* The commission voted to request the Council also to notify counties which have not complied with the state Constitution and Bylaws by filing with the headquarters office a copy of their county society constitution and bylaws, as

follows: "That the Council recommends that each county medical society file a copy of its constitution and bylaws in the headquarters office of the Indiana State Medical Association in accordance with Chapter XXVI, Section 15, of the Bylaws, as it is necessary for county societies to comply with this provision to: (1) prevent conflict with the state and national Constitution and Bylaws; (2) to make societies less vulnerable to law suits; (3) under the present Constitution and Bylaws, a county medical society cannot officially have their delegates seated in the House of Delegates by reason of the fact that they have not complied with the state Constitution and Bylaws."

8. *Commission on Medical Education and Licensure.* DR. PETER PETRICH, chairman, reported on a meeting with Dr. John Nurnberger, acting dean of Indiana University School of Medicine, and the faculty heads on the establishment of a preceptorship program. He announced that the commission is prepared to put this program into operation on a pilot basis beginning in September provided enough preceptors are secured. He asked the councilors to urge their county societies to answer the commission's request for names of physicians who are willing to serve as preceptors.

9. *Recommendations of Commission on Medical Economics and Insurance.*

(1) *Medical review committees.* **The Council, by consent, accepted the following proposal of the Commission on Medical Economics and Insurance concerning medical review committees,** as contained in a letter written by Dr. William H. Garner, Jr., vice-chairman of the commission:

This is a revised copy of the letter which we discussed at the Commission on Medical Economics and Insurance and I believe the following contents are what we agreed on at the meeting. The letter is as follows:

The Commission on Medical Economics and Insurance has reviewed the recent letter referred to it concerning the establishment of a review board for use by the insurance companies to settle insurance disputes. The commission strongly recommends that the Indiana State Medical Association aid the county societies in establishing these review boards.

It has also been recognized that the insurance companies having a desire to utilize this service contact the county medical societies in which the review board should be present.

The Commission on Medical Economics and Insurance welcomes communications concerning the problems arising in this program and since adequate time has not elapsed since the institution of this service no conclusions can be made of its efficiency at this time.

The Commission on Medical Economics and Insurance, however, would like to recommend that at least the following procedure be established in the protocol of the review boards.

1. In matters to be presented to the review board the parties involved submit in writing the problems involved or questioned. That these complaints or disputes shall be available to all parties involved, that is, the physician, the insurance company, the insured and the review board.
2. That the board be open to review only insurance disputes, and that any party involved may initiate review by the board, the insurance company, the physician or the insured.
3. The findings of the board be recommendations only and not binding on the parties involved.
4. The dispute shall be first discussed by the parties involved and if no solution is found then review by the board can be considered.
5. The Commission on Medical Economics and Insurance recognizes that one of the salient problems in disputes is a lack of understanding between the groups involved. It is recommended to the insurance company that simplified and understandable language be used in insurance contracts, so that the insured as well as the physician can read these contracts with full understanding of their context.
6. That both the commercial carriers and Blue Cross-Blue Shield can utilize their use of the review boards and that the review by the boards shall not be limited to any particular insurance group.

At this time it is not recommended that a statewide review board shall be established until such a need is demonstrated.

(2) *Group disability program.* Recommendation presented to the Council that the Indiana State Medical Association endeavor to develop details of a group disability program proposal by various companies, primarily to cover the first year of disability that is not presently covered by the AMA plan. These proposals are to be submitted for approval by the Council. **On motion of Drs. Edwards and Steen the Council directed that this study be undertaken by the Commission on Medical Economics and Insurance, and that the commission report back to the Council or to the House of Delegates.**

Reports of Guests

1. DR. A. C. OFFUTT, State Health Commissioner, reported that the master plan for eradication of tuberculosis had been sent to each physician in the state.

Dr. Offutt requested the Council to make recommendations as to physician members to be appointed to the advisory committee within the framework of the State Board of Health to assist the Bureau of Motor Vehicles in upgrading the physical requirements and examination procedures on applicants for drivers' licenses.

It was taken by consent that the president should nominate five physicians—an ENT man, an ophthalmologist, a general practitioner, an orthopedist and a pathologist—to serve on this committee.

2. DR. DENNIS MEGENHARDT, member of the Blue Cross Professional Advisory Committee, reported that some organizational changes had

been made. Judge Lloyd Claycombe had been advanced from president to chairman of the board, and Guy Spring, formerly executive director, had been made president.

There being no further business, the Council adjourned to meet again at noon, Monday, October 12, 1964, in Parlors B and C, Columbia Club, Indianapolis. ◄

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OCTOBER 1964

The Journal
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Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members. Cost of color illustrations must be shared by the author.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible. However, the right is reserved to reduce in length or reject any article.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication in THE JOURNAL of the Indiana State Medical Association.

Communications dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 1802 North Illinois Street, Indianapolis 2, Indiana. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 3935 N. Meridian, Indianapolis 8.

Advertising rates will be furnished on request. Copy must be received by the 5th of the month preceding month of issue. (Scientific manuscripts must be received at least two weeks earlier if geared for a specific issue.)

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About Our Cover
on page 1131.



This summary of what is happening in Washington is prepared by A.M.A.'s Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

MONTH IN WASHINGTON

WASHINGTON, D. C.—Physician ownership of pharmacies is ethical as long as the patient is not exploited, the American Medical Association told Congress.

Robert B. Throckmorton, AMA general counsel, testified before the Senate Subcommittee on Antitrust and Monopoly that:

"The ownership of a pharmacy by a physician cannot in itself be equated with exploitation. The confidence and trust that the patient reposes in his doctor—to use his knowledge, his skill, his judgment in prescribing medicines and his understanding of the patient's financial problems—preclude a blanket charge of physician-pharmacy-exploitation.

"It would be a disservice to the public and to the medical profession if from these hearings there issued the unwarranted impression that physicians could not be trusted to own pharmacies or to carry on their professional practices in other more important respects without exploiting their patients. It would be unfortunate . . . if a small incidence of violations and alleged violations came to be accepted as 'proof' of widespread unethical practices."

Throckmorton pointed out that both the AMA House of Delegates and the AMA Judicial Council had ruled that it is not wrong, per se, for a physician to have a financial interest in a pharmacy. However, he added, the AMA House of Delegates last year adopted flat prohibitions against physician ownership in a drug repackaging company or controlling interest in a pharmaceutical company while engaged in the practice of medicine. He said that there were relatively few cases of such ownership.

Throckmorton said that less than two percent of the nation's 280,000 physicians have any financial interest in drug repackaging companies.

"Most physicians who acquired financial interests in repackaging firms prior to the AMA statement of policy acted in good faith," he said. "Unless they were a part of the tattered fringe of practitioners who intended to exploit their patients, they had no reason to believe that they were engaging in any unethical act. Many of these physicians who still retain their ownership can, at the most, be censored only for 'good faith misbehavior.' However, any continued ownership, beyond a reasonable period of time to permit severance without undue hardship, should call for the institution of prompt disciplinary action within the ranks of medicine."

NON-PROFIT BLOOD BANKS MAY SOON BE EXEMPT FROM ANTITRUST LAWS

Congressional prospects brightened for legislation exempting community and other non-profit blood banks from the antitrust laws.

Continued



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Bone and joint infections	71	64
Deep-seated or generalized infections	257	251
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Miscellaneous conditions	592	570
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The chief counsel of the Senate Antitrust and Monopoly Subcommittee, Bernard Finsterwald, Jr., said he believed Congress eventually would approve this legislation, backed by the AMA.

The bill was introduced by Sen. Edward Long (D., Mo.) after a Federal Trade Commissioner examiner ruled that community blood banks are subject to antitrust laws and charged the Kansas City area community blood bank with restraint of trade by refusing to purchase blood from commercial, profit firms.

Dr. Gunnar Gundersen, chairman of the AMA Blood Bank Committee and a past-president of AMA, told the Senate sub-committee that:

"The AMA views with great concern the recent decision of the hearing examiner of the Federal Trade Commission finding that human whole blood is a commodity or article of commerce and as such is subject to 'trade' and 'commerce' within the meaning of those terms as used in the Federal Trade Commission Act. The import of this decision is fraught with many dangers and creates serious problems for the physician. Based upon this decision, the physician's and hospital's freedom of choice in selecting blood is severely restricted, lest they be deemed in restraint of trade."

CONGRESS SUBMITS $1 BILLION BUDGET FOR NIH

Congress sent to the White House a record $1 billion budget for the National Institutes of Health.

All told, the bill contained $6.5 billion for the HEW Department's activities during the current fiscal year.

The lawmakers provided $1 million for the long-delayed environmental health center but specified that it be located no closer than 50 miles from the Washington, D.C. area. The Administration sought to have the center located in the Washington suburbs at Beltsville, Md.

Congress approved $222.6 million for the Hill-Burton program of Federal aid for hospital construction, $110.8 million for Federal aid to medical education, and $8 million for tuberculosis control activities.

As the measure finally cleared Congress, the HEW total was $603 million less than the Administration requested, but $942 million more than the House had originally voted.

$283 MILLION PROGRAM FOR NURSES TRAINING

A five-year, $283 million program of federal aid to spur the training of nurses was signed into law by President Johnson.

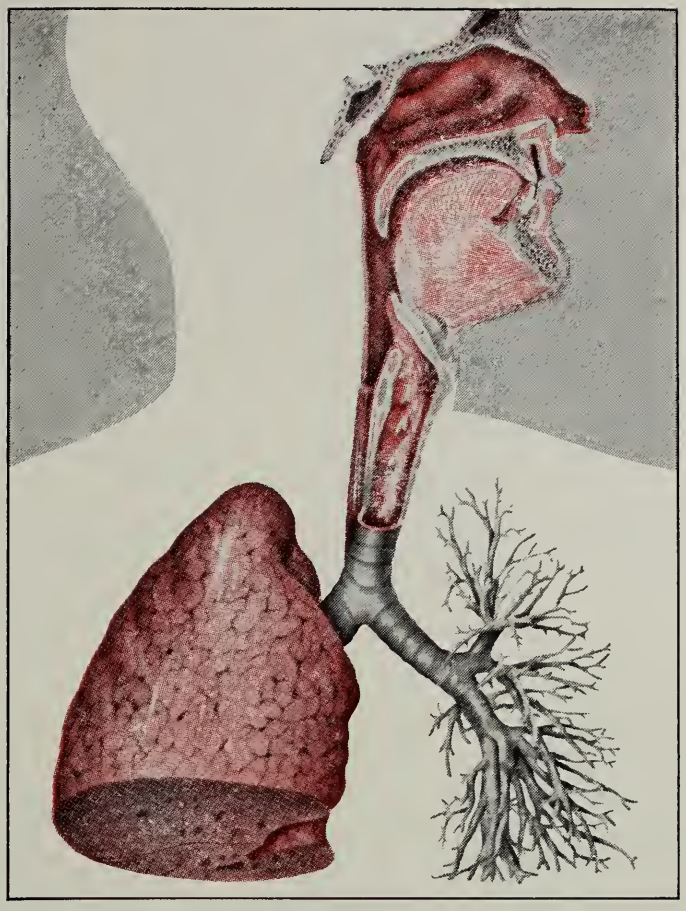
The measure, supported in principle by the American Medical Association, provides for construction grants for collegiate schools of nursing, for grants to help defray the cost of nurses training, for traineeships for advanced training and student loans.

The new law authorizes $35 million over four years as grants to assist in the construction of new facilities for collegiate schools of nursing, or for the replacement or rehabilitation of existing facilities of that type.

It also provides for $55 million in four years for the construction of new facilities for associate degree or diploma schools of nursing or for their replacement or rehabilitation. ◄

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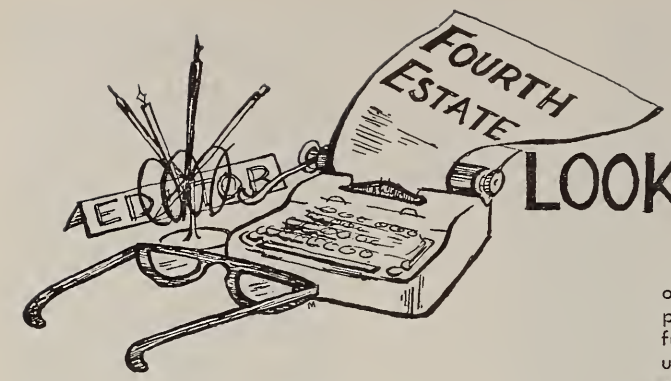
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LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Don't Break A Winning Team

Appeals for the "medicare" proposal include a subtle accusation—sometimes not so subtle—that medical care for Americans, especially the elderly, has been and is being neglected.

The cure for this neglect, of course, is supposed to be Federal taxpayers' money.

Yet what's the reason the numbers of elderly persons—and hence the varieties of political proposals aimed at them—are so high these days? The average life expectancy in the United States was 47 years in 1900. In 1959 it was 70 years. What brought it up?

Better living conditions had something to do with it. But mostly it was medical advancement.

Here are some items. They are taken from an article in "Spotlight," publication of the Committee for Constitutional Government, written by Edward Wimmer, vice-president of the National Federation of Independent Business.

In 1940, the cost of combating a case of pneumonia was reckoned at three months' wages of the average working man, to pay the hospital and other bills. In 1959, five days' wages for medicine and a few days in bed at home took care of it.

A few years ago polio was the dreaded scourge of summer. Now the incidence of this disease has been cut 85% from the 1940 rate.

In 1946, 16,000 persons were stricken with diphtheria. In 1959, there were fewer than 1,000.

There were 50,000 deaths from tuberculosis in 1945; only a fourth of that number in 1959.

Seven thousand children died from whooping cough in 1940. The death figure for 1959 was 310.

Rickets, scurvy, scarlet fever and infant diarrhea have almost disappeared.

Such comparisons as these—and there are many others which could be cited—indicate that medical care is anything but neglected in this country.

The record argues against any fundamental change in the system through the device of Federal intervention.—*Indianapolis Star*, June 16, 1964.

New Insecticide Needed

Various members of the insect family are an accepted part of the summer season.

What's a picnic without an ant invasion? And a soft summer night without the familiar buzz of a hungry mosquito?

Yet we still don't like most of them, and science has provided us with an assortment of sprays and repellents with which to do battle.

One bug, however, is apparently immune — the species becomes more numerous every year. We refer to the litterbug. There must be some way to exterminate him.

Why do people throw beer cans, pop bottles and other junk from moving cars to clutter up the roadside? Why do they drop candy wrappers and empty cigarette packs to the sidewalk? These examples, of course, are only a few among the dozens of thoughtless acts in which the litterbug specializes.

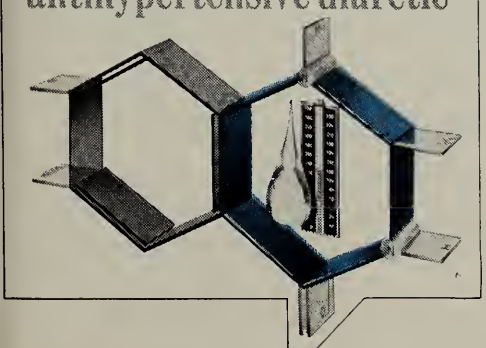
Do they act like this in their own homes? Sounds impossible, but maybe they do.

Each year there are campaigns against

Continued on page 1130

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CONTRAINDICATION: Anuria.

1. Steigmann, F., and Griffin, R.: Evaluation of Quinethazone, a New Diuretic. J. Amer. Geriat. Soc. 11:945 (Oct.) 1963.

2. Schwartz, M.: Office Evaluation of a New Diuretic in Patients with Hypertensive Diseases. Scientific Exhibit Presented at the Clinical Meeting of the American Medical Association, Los Angeles, California, Nov. 25-28, 1962.

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litterbugging, based on the assumption that all of us have good manners. Apparently the assumption is wrong. There are laws against it, but the litterbug ignores the law, too.

As we said, science has given us many repellents and sprays. We need one more.—*Gary Post-Tribune,* reprinted in *The Indianapolis Star,* July 22, 1964.

Why Not Erasers?

More than $4,000 in United States foreign aid money was spent for sex stimulants for Formosa in a recent year, the opposition charged during the brief House debate on the foreign aid authorization bill.

More than $1,500 was spent on prophylactics for Turkey, they charged.

Other items were quoted by the opposition to strengthen the argument that foreign aid should be curtailed. The purchases, which were admitted by the Agency for International Development itself, were as follows:

Country	*Purchase*	*Amount*
Cambodia	Metrecal	$17,070
Cambodia	Sun lotion	59
Turkey	Air Wick	10,650
Turkey	Eye shadow	199
Turkey	Lipstick	741
Turkey	Bubble gum	999
Turkey	Prophylactics	1,587
Pakistan	Deodorants	1,042
Dominican Republic	Hops	5,131
Formosa	Sex stimulants	4,010
Formosa	Royal Bee Jelly	13,500

An appropriate appropriation in a rider that should have been attached to the bill would have provided a purchase for its authors—erasers.—*Indianapolis Star,* Aug. 26, 1964.

Kill The Golden Goose?

Predictably, the Democratic Party's platform writers—who can smell a vote-getter 150 yards upwind from a rendering plant—have again slapped a "must" label on the scheme of broadening Social Security coverage to include medical care for the aged.

And, even as this election year nobility was being prattled around Atlantic City, the administration's supporters led by Senator Abraham Ribicoff were already preparing a rider on the House bill boosting Social Security benefits that would make this a reality.

From its very inception, unfortunately, the humanitarian aspects of the whole Social Security program have been obscured by the clock-like regularity with which both political parties have taken it on as a political football. The truth of the matter is that the program cannot avoid being kicked to death eventually.

For the first time, in 1963, the Social Security program paid out more than it took in—a danger sign by anyone's yardstick—and also reached the point where the combined contribution from employer and employee would be enough to buy an equal retirement annuity from a private insurance company, payable beginning at age 65—with no strings attached—and with the usual loan values found in commercial policies. The bargain days are over, in other words. And as the politicians continue to broaden Social Security's bite out of the worker's paychecks, the more he will continue to pay for relatively less coverage.

No one can deny that medical care for all of the aged is a desirable goal, but it is one that is steadily being achieved by the commercial insurance companies under their "Golden Age" group policies at a cost to the individual that is less than the projected increase in his Social Security payments would be.

To argue against the inclusion of medical care under the Social Security program is painted by the Liberals as a form of the most backward sort of reactionary behavior. This ignores the over-riding fear that prompts so much of the opposition to the plan: That Social Security is the big hope of too many millions of Americans to be allowed to collapse through the fiscal irresponsibility of vote-grabbing politicians of either party—*Indianapolis Star,* Aug. 27, 1964.

The Wrong Approach

A free economy and society expands the opportunities for all its members but leaves it largely to them to decide what they will

do about it. This is the antithesis of the present sociological approach, which regards the poor as a segregated class; either they must be dragged out of their poverty by mechanical government programs or else maintained in their poverty by the rest of society. Since there are always those only too willing to live at the expense of others, that approach may only swell the ranks of the shiftless and help perpetuate poverty. —Editorial, *Wall Street Journal*, reprinted from *Medicine at Work*, Sept., 1964 ◄

About Our Cover

There is greater freedom of choice in America today than in any other nation in the world.

Former President Herbert Hoover, on the occasion of his 90th birthday in August, issued a statement on the greatness of America. In it he said, "There are a dozen or so other freedoms which are not a matter of specific law — such as the freedom to choose our own callings, freedom to quit a job and seek another, freedom to buy or not to buy . . . In short, we have freedom of choice."

For countless centuries, man has sought a simple, quick and accurate way of expressing and recording the wishes of the people. Man has "voted" by the clashing of spears on shields, vocal clamor, balloting with shells and bronze disks, placing a pebble or little ball in an urn and so forth.

The first record of the use of the ballot in America was in 1692 when members of the Salem church chose their pastor. The Australian ballot, that of marking an "X" in a box for the candidate of your choice, was introduced in this country in 1888. And the voting machine of today is the result of a 65-year program of continuous invention, development and improvement.

There is a very familiar saying that the man who screams the loudest about an elected official is the one who didn't vote. Don't allow yourself to be put in this category.

Physicians are among the most influential citizens in any community — big or small. They must accept their full and complete responsibility as American citizens and either support the man of their choice or simply declare their unhappiness with things as they are.

And they should remember that their patients, too, can be greatly influenced by their thoughts.

Get out the vote — and vote yourself — on November 3.—J.F.S.



and it's not a once-over-lightly one, either. All rubber stoppers used in Lilly ampoules are scrupulously cleaned with a detergent and hot deionized water in a special washing machine like the one pictured above. This removes any foreign matter adhering to them. Then the stoppers are autoclaved at 120° to 121°C. for one hour. They are now clean, sterile, and ready for use. In case the stoppers are not used within seventy-two hours, they are returned for resterilization. ☐ This meticulous process is only one of the many safeguards to insure the quality of the finished product and to protect the ultimate user.

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Use of Acetohexamide (Dymelor)* in Diabetic Patients with Secondary Failures to Antidiabetic Drugs

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THERE ARE A NUMBER of effective and safe oral hypoglycemic drugs on the market for use in diabetic patients. For the most part, these preparations serve well the purposes of antidiabetic medication in suitable cases. It is well known by all clinicians that sooner or later these preparations may lose their effectiveness to some degree, leading to loss of carbohydrate tolerance (known as secondary failure). At such times, physicians are compelled to resort to the use of insulin, or increase the dosage of the drug being used (with the attendant danger of toxicity from the increased dosage) or find another, more potent drug or combinations of drugs.

For approximately two and one-half years, the author has employed acetohexamide (Dymelor, Lilly) in various dosages and in combination with other antidiabetic drugs in an attempt to overcome the loss of tolerance which occurs in secondary failure.

Materials and Methods

There were 27 patients in this study of whom 17 were private and 10 from the Diabetes Out-Patient Department of Mt. Sinai Hospital, Cleveland, Ohio. Each patient was started on acetohexamide only after a secondary failure with previously used drugs or combination of drugs. These conditions pose a challenge to any drug which might be prescribed inasmuch as patients in secondary failure are quite resistant to further administration of oral antidiabetic preparations.

The carbohydrate metabolism was gauged on each visit by quantitative analysis of glucose in the entire 24-hour urine excretion by Somogyi's method. As can be seen in Table 1, quantitative measurements of glucose permit comparisons of the efficacy of the various antidiabetic drugs. As in the case of insulin, we have found arbitrarily that a 24-hour excretion of 10† grams of glucose or less is a satisfactory level of diabetic control from every standpoint and quite acceptable to diabetes-oriented physicians in general. When the 24-hour glucose excretion fails to drop below 10 grams after a patient has taken a given drug or combination of drugs four weeks or longer, either another preparation or a larger dosage of the same preparation is prescribed. Or, as frequently happens, when the previously

* This study was conducted with the support of Eli Lilly & Co., Indianapolis

† The 10 gram rule applies particularly during treatment with insulin. In the case of oral drugs, the hazard of hypoglycemia is not so great and it is possible safely to attain 24-hour excretions of less than 10 grams. (See Table 1.)

EFFICACY OF VARIOUS ANTIDIABETIC DRUGS AND COMBINATIONS ON ONE PATIENT

Date	Preparation Used	24-Hr. Glucose Excretion	Rank*
12/3/56	Diet alone	12.5 Gm.	
12/10/56	Tolbutamide 0.5 Gm. b.i.d.	0	(9)
3/17/58	Tolbutamide 0.5 Gm. b.i.d.	15.0 Gm.	
4/14/58	Tolbutamide 0.5 Gm. t.i.d.	0+	
8/18/58	Tolbutamide 1.0 Gm. b.i.d.	0	(8)
1/12/59	Tolbutamide 1.0 Gm. b.i.d.	7.5 Gm.	
1/20/59	Chlorpropamide 250 mg. b.i.d.	0	(7)
3/7/60	Chlorpropamide 250 mg. b.i.d.	9.6 Gm.	
3/14/60	Chlorpropamide 250 mg. t.i.d.	9.6 Gm.	
3/18/60	Chlorpropamide 500 mg. b.i.d.	0	(6)
9/18/61	Chlorpropamide 500 mg. b.i.d.	12.5 Gm.	
10/16/61	Chlorpropamide 250 mg. + DBI 25 mg. b.i.d.	0	(5)
1/29/62	Chlorpropamide 250 mg. + DBI 25 mg. b.i.d.	12.5 Gm.	
3/12/62	*Acetohexamide* 500 mg. b.i.d.	0	(4)
5/18/62	*Acetohexamide* 500 mg. b.i.d.	11.2 Gm.	
11/19/62	*Acetohexamide* 500 mg. b.i.d.	12.5 Gm.	
1/7/63	*Acetohexamide* 500 mg. t.i.d.	11.2 Gm.	(3)
2/11/63	*Acetohexamide* 500 mg. t.i.d.	0	
3/11/63	*Acetohexamide* 500 mg. t.i.d.	15.0 Gm.	
4/8/63	*Acetohexamide* 500 mg. t.i.d.	10.0 Gm.	
5/13/63	*Acetohexamide* 1 Gm. b.i.d.	0	(2)
10/21/63	*Acetohexamide* 1 Gm. b.i.d.	12.4 Gm.	
12/13/63	*Acetohexamide* 500 mg. b.i.d. + DBI-TD 50 mg. q.d.	0	(1)
2/24/64	*Acetohexamide* 500 mg. b.i.d. + DBI-TD 50 mg. q.d.	0	

* Each antidiabetic drug or combination of drugs in various dosage is ranked according to its efficiency in every patient. The criterion of efficiency is evaluated by repeated quantitative analysis for glucose (Somogyi method) in the total 24-hour urine collection. For example, when drug A fails to reduce the 24-hour glucose excretion to the desired level, viz, 1-10 Gm., and drug B is effective in this regard, the latter (drug B) is ranked #1 and drug A is ranked #2. Should a third drug be required for this purpose in event of failure and prove more effective, it is given the highest rating — #1 — and the others successively lowered in rank (2, 3 etc.)

TABLE 1

satisfactory glucose excretion begins to exceed the prescribed limits, another dosage or combination is tried.

When more than one tablet is prescribed, they are given in divided doses following breakfast and dinner. This is in order to avoid any possible gastric irritation. When two different drugs are used in combination, they are taken together after breakfast. When a second dose is required it is given after dinner. It should be remembered that, unlike insulin, oral antidiabetic drugs produce their effect by creating blood levels throughout the 24-hour day.

There were 19 females and eight males in this series. They used acetohexamide from 14 days to 854 days, an average of 273 days per patient. Random patients were tested before and after the use of acetohexamide for possible hepatic, renal or hematopoietic

RELATIVE EFFICIENCY OF ACETOHEXAMIDE AND OTHER ANTIDIABETIC DRUGS (THREE OR MORE PATIENTS)

Antidiabetic Drug	No. Cases (3 or more)	Rating	Rank*
Acetohexamide - 1.0 Gm. + DBI - 50 mg.	5	1.0	1
Acetohexamide - 1.0 Gm. + DBI-TD - 50 mg.	10	1.5	2
Chlorpropamide - 500 mg. + DBI - 50 mg.	11	2.1	3
Tolbutamide - 1.0 Gm. + DBI - 50 mg.	3	2.3	4
Acetohexamide - 2.0 Gm.	7	2.4	5
Acetohexamide - 1.0 Gm.	20	2.52	6
Acetohexamide - 1.5 Gm.	10	2.7	7
Tolbutamide - 1 Gm. + DBI 50 mg.	3	3.0	8
Chlorpropamide - 750 mg.	5	3.2	9
Chlorpropamide - 1000 mg.	3	3.3	10
Chlorpropamide - 500 mg.	7	3.7	11
Tolbutamide - 1 Gm. + Chlorpropamide - 500 mg.	7	3.7	11
Tolbutamide - 2 Gm.	19	4.0	12
Tolbutamide - 1.5 Gm.	18	4.27	13
Tolbutamide - 1.0 Gm.	21	4.9	14
	149		

* See footnote, Table 1.

TABLE 2

RELATIVE EFFICIENCY OF ACETOHEXAMIDE AND OTHER ANTIDIABETIC DRUGS (LESS THAN 3 PATIENTS)

Antidiabetic Drug	No. Cases Less than 3	Rating	Rank
Acetohexamide - 500 mg. + DBI-TD - 50 mg.	1	1	1
Chlorpropamide - 250 mg. + DBI - 25 mg.	1	1	1
Tolbutamide - 1 Gm. + DBI-TD - 50 mg.	1	1.5	2
Chlorpropamide - 250 mg.	1	2	3
DBI-TD - 50 mg.	1	2	3
Chlorpropamide - 250 mg. + DBI - 75 mg.	1	2	3
DBI - 75 mg.	1	3	4
Tolinase - 200 mg.	1	3	4
Tolbutamide - 0.5 Gm. + Chlorpropamide - 250 mg. + DBI - 25 mg.	1	3	4
Tolbutamide - 0.5 Gm.	1	4	5
Tolinase - 100 mg.	1	4	5
DBI - 50 mg.	2	4	5
Carbutamide - 1 Gm.	1	7	6
DBI - 100 mg.	1	8	7
	15		

TABLE 3

damage.

The relative efficacy of the acetohexamide preparation as compared with the other antidiabetic drugs is shown in Tables 2 and 3. Each dosage or different drug or combination is classified. Inasmuch as the 27 patients in this study averaged somewhat more than six preparations each, they represent the equivalent of 164 patients for purposes of statistical comparison. By this yardstick there were 53 patients who used acetohexamide in various dosages or combinations. Thus, in Table 2, the 27 patients utilized 149 different preparations three or more times. In Table 3, each preparation was prescribed less than three times (15 cases) — a total of 164 trials.

The 17 private patients in this study used acetohexamide from 14 days to 854 days, an average of 347 days per patient at the time of this report. Since the drug was started later in the O.P.D. group, it has not been prescribed as long. The 10 O.P.D. patients averaged 77-210 days, an average of 148 days per patient.

Column one in Tables 2 and 3 lists the number of patients in whom each antidiabetic drug was used in specific doses or in combination with other drugs. In column two, each drug or combination of drugs is listed in order of efficiency as compared with all the other preparations used in a given patient. For example, in Table 1 the following preparations were used: tolbutamide, chlorpropamide, chlorpropamide with DBI,* acetohexamide and acetohexamide with DBI. It can be seen that they ranked as follows in the order of their effectiveness: (1) acetohexamide 500 mg. twice daily plus DBI-TD, 50 mg. (2) acetohexamide 1 Gm. twice daily, (3) acetohexamide 500 mg. three times daily, (4) acetohexamide 500 mg. twice daily, (5) chlorpropamide 250 mg. plus DBI 25 mg. twice daily, (6) chlorpropamide 500 mg. twice daily, (7) chlorpropamide 250 mg. twice daily, (8) tolbutamide 1.0 Gm. twice daily and (9) tolbutamide 0.5 Gm. twice daily.

When all the drugs are tabulated in the order of their efficacy and compared with others, they are rated in column three in the order of their antidiabetic effects in all the patients in whom they were used.

* Phenformin hydrochloride.

Results

The four most effective antidiabetic responses are obtained with a combination of two drugs (Table 2). In this study, in which acetohexamide was prescribed in 27 patients, two combinations, viz., acetohexamide, 500 mg. twice daily and DBI, 25 mg. twice daily and acetohexamide, 500 mg. twice daily plus DBI-TD, 50 mg., once daily, ranked first and second respectively.

In the patients who used acetohexamide alone, (Table 2) acetohexamide, 1 Gm., twice daily, ranked fifth and was closely followed by lower doses of acetohexamide, i.e., 500 mg. twice daily, and 500 mg. three times daily in sixth and seventh positions. Thus acetohexamide outranks the other antidiabetic drugs used in these patients and in some cases proves more effective than combinations of tolbutamide with DBI or with chlorpropamide.

In Table 3, which is statistically less significant because each drug or combination was used less than three times, there is nevertheless a similar trend indicating that combination of two preparations is more effective than larger single doses of either drug.

Side Effects

It is gratifying to find an almost complete absence of toxicity in the 27 patients using acetohexamide in spite of the fact that the drug was used on an average of 347 days per patient and well over two years in several. One patient developed urticaria after taking acetohexamide for 24 hours. One patient developed hypoglycemia on a dosage of acetohexamide of 500 mg. twice daily after a period of only three days. As in the case of hypoglycemia with other antidiabetic drugs, this patient had taken an insufficient quantity of food. In fact, there had been a preceding weight loss almost to the point of starvation. Moreover, the patient was unable to comprehend at all the importance of food to counteract the hypoglycemic effect of the drug.

Following a period of time using acetohexamide, various laboratory tests were performed on 16 of 27 patients in this

study. These included red and white blood cell counts, differential counts, hemoglobin and hematocrit; urinalysis including pH, albumin, specific gravity and microscopic examination; blood urea nitrogen; cephalin flocculation and thymol turbidity. As can be seen in Table 4, with the exception of case #126, there were no significant abnormalities pointing to organ damage after long periods of consuming acetohexamide in various dosages and combinations. Moreover, there was no complaint or clinical suspicion at any point along the line pointing to dysfunction of any of these vital organs.

Comment

There is an excellent array of effective, relatively nontoxic antidiabetic drugs available at present to the physician treating diabetes mellitus. At first sight, there would appear to be little or no need for the introduction of additional hypoglycemic preparations. However, it is inherent that sooner or later all the known antidiabetic oral drugs tend to diminish in effectiveness or lose entirely their ability to regulate carbohydrate metabolism—so called secondary failure. In the absence of a more potent oral antidiabetic drug or combination of drugs, this situation necessitates resort to insulin.

During the past two years, the author has had the opportunity to evaluate acetohexamide (Dymelor, Lilly) in a series of diabetic patients who developed secondary failure when taking one or more oral antidiabetic drugs or combinations. In this study, acetohexamide was employed in 27 patients in dosages of 1 Gm., 1.5 Gm. or 2.0 Gm. daily. It was also prescribed in 16 of these 27 patients in combination with DBI —1 Gm. of acetohexamide with either 50 mg. DBI or 50 mg. DBI-TD. Since one or more dosages or combinations was employed in some patients, acetohexamide was actually used 53 times (Tables 2 and 3).

The patients included in this series were reviewed at two-four week intervals and a

LABORATORY RESULTS IN PATIENTS TAKING ACETOHEXAMIDE

Case	Blood Urea Nitrogen	Urinalysis	Differential Blood Counts					Cephalin Flocculation		Thymol Turbidity	Red Blood Count	White Blood Count	Hemoglobin	
			N	L	M	E	B	24-hr.	48-hr				%	Gm.
126	18.6	Alb. 2+						3+	4+	4.2	5.6	7450	100	15.5
132	19.1	Neg.						0	0	1.3	5.12	5750	92.9	14.3
133	16.0	WBC 8-10						2+	3+	2.1	4.69	5350	87.1	13.5
137	19.1	WBC 4-6						2+	3+	1.5	4.85	8800	92.1	14.3
138	15.0							0	2+	1.3	5.21	8500	97.4	15.1
N.G.	14.0		55	39	5	1		0	0	1.5	Hematocrit 44	4500		
M.G.	17.0	Neg.	49	38	8	3	1	0	0	0.4		6200		13.0
M.S.		Alb. tr. Many WBC 2-4 RBC	54	32	7	4	1	3+	3+	3.3	49	3150		
L.C.	19.0	Alb. 2+	42	46	11		1	+	+	0.9	38	5700		
B.A.	12.0	1-5 clumps WBC	62	24	8	1				2.4		5950		
			Atypical Lymphs 4											
L.L.	10.0	Few WBC	59	24	14	2	1				37.5	5850		11.9
V.M.	12.5	Alb. 3+	56	30	11						32.5	5800		
F.H.	14.0	Neg.									35	7200		12.1
C.S.		Neg.	48	40	11	1		0	0		42.5	6900		
M.S.	11.0	Sl. tr. Alb. Loaded WBC	58	28	10	3	1	0	0	0.2		7250		
G.C.	16.5	Alb. 1-2 WBC 5-8									40			

TABLE 4

complete 24-hour urine collection was examined quantitatively for glucose at each visit. As can be seen in Table 1—an actual case study—the results obtained with one antidiabetic preparation can readily be compared with the previous drug and subsequent ones, making possible a relatively accurate rating of the effectiveness of each (Tables 2 and 3). It can be seen in this group of cases that acetohexamide proved to be superior to either tolbutamide or chlorpropamide and to several other antidiabetic drugs in a few cases (Table 3).

The author has had a favorable experience with combinations of the various antidiabetic preparations. Consequently, in patients in whom acetohexamide proved ineffective in 2 Gm. dosage, combinations of acetohexamide, 1 Gm., with either DBI, 50 mg., or DBI-TD in 50 mg. or 100 mg. doses were tried. Both combinations proved superior to all other agents in 16 of the 27 patients in this series (Tables 2 and 3). Aside from the excellent effect on glucose excretion, combinations have the additional advantage of using low doses of each drug. This diminishes the liklihood of toxicity and hypoglycemia.

Insofar as hepatic, renal and hematopoietic abnormalities are concerned, acetohexamide proves to be a remarkably safe antidiabetic drug. There was no clinical evidence of organ damage at any time in the patients in this series. Various laboratory examinations performed in 16 patients of this group who took the drug over a long term failed to uncover any significant abnormalities (Table 4). ◄

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The Ways of Propaganda

What the pharmaceutical industry has spent defending itself in Washington and other parts of the world the last four years, in terms of manpower and money, is staggering. What started out as differences of opinion between our industry and some government investigating committees has now become the source of distorted international propaganda—not so much anti-drug industry as it is anti-American.—Philip B. Hofman, Chairman of the Board, Johnson & Johnson, to National Association of Chain Drug Stores, Washington, D. C., October 17, 1963.

Toxic Epidermal Necrolysis

Report of Two Cases

ROBERT E. HANNEMANN, M.D.
Lafayette

TOXIC EPIDERMAL NECROLYSIS is a rare but recently much-discussed skin problem. It was recognized and named by Lyell in 1956.[7] Apparently the disease was first reported by Lang and Walker[6] in that same year but was classified as an "unusual bullous eruption." It has also been called the scalded skin syndrome.[3]

The first reported American case was by Potter in 1960.[8] Since then the author has found five other cases in the literature involving American patients.[1,4,5] The purpose of this article is to briefly review the entity and report two cases.

History

Lyell's original description involved four cases. He described them in the following way: "In all of them, large areas of skin have loosened. The loosening has been preceded by erythema and tenderness and has been followed by peeling, so that a dark red, excessively tender surface has been revealed which has healed rapidly without scar formation. In three of these cases, fluid collected beneath the loose skin and formed flaccid blisters. The clinical resemblance to scalding was close, both in appearance of the lesions and in the sensations of the patient, but it is not complete in that there was no shock or exudation as one sees with a scald."

Lyell felt that this condition needed to be differentiated from erythema multiforme, dermatitis herpeteformis and lesions of pemphigoid nature. He felt that this could be done histologically because in toxic epidermal necrolysis, the damage was confined to the epidermis while the dermis was involved in these other conditions.

Lyell also mentioned Nikolsky's sign in his original article. This is loosening of the epidermis caused by friction over the surface. It is present in various other skin conditions as well as the one under discussion.

In 1962, Beare published a complete and excellent review of this condition.[2] At that time there were 45 reported cases in the literature. Most of these were from South Africa and England. All age groups and races were involved.

Numerous medications have been thought to be related to the development of this condition but none has been definitely proven to be causative. In many cases there have been no medications used prior to the eruption. The latest case has been related to the use of sulfadimethoxine (Madribon).[5]

There is also some question as to whether this condition is what was formerly called acute pemphigus or "butcher's pemphigus."[8] This was a term applied to an acute epidermolysis associated with a bacterial septicemia.

Diagnosis

In making a diagnosis of a newly named or reported condition, the author believes it wise to adhere as closely as possible to the original describer's criteria. It is also necessary to rule out all other known possibilities. It seems that the following conditions must be considered when seeing an eruption such as this: 1) erythema multiforme, 2) dermatitis herpeteformis, 3) pemphigus, 4) Stevens-Johnson syndrome, 5) Ritter's disease and 6) drug reaction.

Erythema multiforme usually begins with the abrupt appearance of a rash. There may be preceding illness of varying degree. The individual lesions vary from macules to vesicles and blebs. There is usually no severe itching or pain prior to the eruption. The Stevens-Johnson syndrome is thought to be a severe form of this disease with involvement of the mucous membranes of the eyes and mouth. In both these conditions there is often complete necrosis of the

* From the Department of Pediatrics, The Arnett Clinic.

epidermis and inflammatory infiltrate in the dermis.

Pemphigus (pemphigus vulgaris) is seldom seen in children. There is usually no preceding illness such as in toxic epidermal necrolysis. The involved areas may itch but are not painful in the same manner as toxic epidermal necrolysis. The skin also does not peel in the same manner. Lyell reported that the blister fluid in pemphigus contained epidermal cells; but in toxic epidermal necrolysis, the fluid does not.[7]

Ritter's disease is a term usually reserved for a neonatal condition. It is considered to be infectious in origin and involves rapid, universal desquamation.

Drug reactions include a wide variety of skin manifestations. This, the author believes, is the most difficult condition to rule out in any skin manifestation. This is especially true in cases of toxic epidermal necrolysis because there is usually a preceding illness which seems to warrant drug therapy. It would seem, however, that the skin condition should recur if the drug is either continued or introduced on another occasion. This has not been true.

The treatment of toxic epidermal necrolysis has generally been supportive as in burn cases. There has been use of antibiotics and steroids. Beare feels that steroids may prevent the formation of blisters and the subsequent exfoliation.[2]

Case Report No. 1

The patient was a five-year-old white boy. He was first seen on June 24, 1963, because of generalized pain and a rash. He had complained of not feeling well on June 22. His mother noted some skin erythema at that time, but thought that he might have been sunburned.

His recent health history revealed that he had been treated with erythromycin (Ilosone) for a bilateral otitis media on May 6, 1963. The antibiotic was changed to demethylchlortetracycline (Declomycin) on May 9. On May 13, sulfadimethoxine (Madribon) was tried for approximately one week; he was then seen by his family physician on May 31 and was thought to be recovered. Approximately ten days prior to his first visit to my office he had a mild upper respiratory infection. This was treated with a triple antihistamine syrup (Triaminic). He apparently recovered from this and was thought to be well until the onset of his current illness.

Physical examination revealed a well-developed boy. His axilla temperature was 100°. He had an erythema of the face, arms and trunk with some slight involvement of the mucous membranes of the mouth and eyes. There was a circumoral pallor and an exudative tonsillitis. The affected skin areas were warm to the touch. He complained when his extremities were moved although he denied joint pain. A diagnosis of scarlet fever was made, a throat culture was obtained and he was started on penicillin therapy.

On June 25, 1963, his pain became worse and he was hospitalized. Physical examination on that date revealed a very irritable child who preferred to be on his back with hips and knees flexed. He complained of pain whenever he was asked to move. His temperature was 99.4° rectally. He still had a bright erythema of the trunk, face and arms. He had flaccid bullae on his forehead, lower eyelids, and chin and there was an irregular erythema on the mucous membranes of the mouth. The tonsils were still edematous with small amounts of exudate present. Ruptured bullae were noted on the right lateral chest wall near the axilla. He had a positive Nikolsky's sign.

Laboratory work revealed the following: CBC: hemoglobin 11.0; hematocrit reading 33; white blood count 11,450 with 46 segmented cells, 49 lymphocytes, one monocyte, three stab cells, one eosinophile.

Urinalysis: normal.

Anti-streptolysin O titer: 50 Todd units.

C-Reactive Protein: +

Sedimentation rate: 23 millimeters per hour.

Throat cultures: 6/24/63—Non-hemolytic, gram positive cocci in clusters.

6/25/63—Staphylococcus aureus, coagulase positive; gamma streptococci, (both were sensitive to penicillin).

Chest x-ray: normal.

EKG: normal.

The patient was placed in isolation and penicillin therapy was continued. On June

26, he was having less pain but bullae of the same flaccid variety were noted on the hands, chest and back. On June 27, new lesions were noted on the arms, but his face and trunk were clearing. A functional-sounding heart murmur was detected at the lower left sternal border on that date. Nearly all the erythema was gone on June 28 but he had a positive Nikolsky's sign on the lower abdomen. He was allowed out of bed on June 30; the following day small bullae were noted on the soles of the feet. He was released from the hospital on that day.

He was seen again one week after discharge. At that time he had no erythema. His skin, including that of the palms and soles, was desquamating. His heart murmur was evaluated by a cardiologist and was thought to be functional. Since then he has remained normally healthy.

Case Report No. 2

The patient was a 20-month-old white girl who was seen in the office on June 10, 1964. She was brought in because she had had an upper respiratory infection for five days, and was having a low grade fever and an unusual rash. She had been treated with aspirin and brompheniramine maleate (Dimetane) in appropriate dosage. Physical examination revealed a very irritable child. The rectal temperature was 101°. The shoulders and face were brightly erythematous, similar in appearance to sunburn. There was a generalized erythema of the remainder of the body except the lower arms and legs. The child seemed to have pain when touched.

The throat revealed a markedly edematous pharynx and tonsils. There was white exudate on the tonsils; penicillin therapy was begun after a throat culture was obtained. The mother called later in the day to report that the child was beginning to have rather large blisters forming on the face. Her irritability had also increased. She was hospitalized that afternoon. Her temperature at that time was 100.4°. Her physical findings were essentially the same except that flaccid bullae were appearing rather rapidly over the face, neck and upper trunk. Laboratory work revealed the following:

CBC: hemoglobin 11.5; hematocrit reading 43; white blood count 23,100 with 72 segmented cells, 17 lymphocytes, 9 monocytes, one stab cell and one eosinophile.

Urinalysis: Normal.

Throat culture: June 10, 1964 revealed Neisseria catarrhalis and gram positive cocci which were coagulase negative and which were sensitive to nearly all antibiotics including penicillin.

On June 11, 1964 the child was much worse. The superficial skin layers on her face were almost completely gone. She had marked crusting around the nose and eyes. Sterile technic was instigated. Her temperature on this day ranged between 99 and 100°.

On June 12, the skin involvement on the trunk was more extensive. Her tonsils still showed a patchy exudate. Her temperature ranged between 99 and 101°. She was started on Achromycin. Her disease seemed to be characteristic of toxic epidermal necrolysis. To verify the diagnosis, a skin biopsy was performed on June 13. The report was compatible with toxic epidermal necrolysis. On June 14, she began to improve; the change was quite rapid. On June 15, it was possible to start cleansing her skin with dilute PhisoHex. On June 18, the Achromycin was discontinued. She was sent home on June 19, 1964. At the time of her release, she had involvement of all areas of her body except the palms and soles. She was seen approximately one week later at which time there was evidence of ruptured bullae on these areas.

Comment

The author believes that these two patients represent clinical cases of what Lyell described in his original article. The following seem to be good criteria for making this diagnosis:

1) Preceding illness—usually an upper respiratory infection.

2) Sudden appearance of *red, painful* skin, strongly resembling sunburn or scald.

3) Bullae formation in 12-24 hours after the onset of erythema and pain. These bullae are flaccid and easily ruptured.

4) Positive Nikolsky's sign.

5) Histological evidence of epidermal necrolysis with little or no involvement of the dermis.

Lyell seemed to depend strongly on the clinical picture in defining this entity. The author believes that the four clinical points above are in agreement with his description. The histological picture is good supporting evidence. Many of the reported cases have not had a skin biopsy, however. It is understandable why this was not done when one sees the obviously painful skin that is present in these cases. Qualified dermatologic consultation, as was obtained in the first case, can be helpful in defining the problem in absence of skin biopsy.

It is interesting to note that both of these cases occurred during the month of June. Both children are from families with relatively prominent allergic histories. Both children also had an exudative tonsillitis at the time of this illness. One might speculate that this condition is a hypersensitivity reaction to an infecting virus or bacteria and/or its toxins. Certainly, the rash, in its early stages, strongly resembles that of scarlet fever.

Summary

Two cases of toxic epidermal necrolysis (the scalded skin syndrome) are presented. A rare skin condition of unknown etiology, it involves painful erythema followed by flaccid bullae formation and subsequent desquamation. The diagnosis can be made by the typical clinical picture and/or skin biopsy.

Treatment is general supportive care.

Acknowledgment

The author wishes to acknowledge the assistance of the medical libraries of the Indiana University Medical Center and Eli Lilly & Company of Indianapolis. The help of the publicity and library departments at St. Elizabeth Hospital of Lafayette is also greatly appreciated.

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The Case of the Lilt of Love's Lullaby

ARNOLD LIEBERMAN, M.D.
New York, N.Y.

OVER THE DECADES, we doctors accumulate memories of patients treated poorly, indifferently or even with flashes of brilliance. We become father confessors and confidants of the young and the old. People come to us for life or death verdicts which they accept with total faith. We establish conditioned reflexes and make diagnoses that—sometimes—pass for the miraculous* even when we make the more modest statement that it is *experience* guiding us. Luke Fildes' painting, "The Doctor", is justly famous for conveying visually what I am fumbling to express verbally.

The doctor-patient relationship has been deteriorating in these days of hired, session workers and so much per diem home care physicians. Strikes by doctors in Canada and Belgium may be ever so justified but they sound strange to my ears. They are a sad commentary on the vanishing family physician. But let us stop editorializing and get down to Rosita Robles.

My address sounds swanky, Fifth Avenue; however, right in back of the beautiful co-op facing Central Park, is Harlem; just a few blocks further east is an area rated "most blighted" in all New York! Within sight of Flower and Fifth Avenue and Mount Sinai hospitals are whole grimy rows of tenements slated for demolition. Absentee landlords collect exorbitant rents and do absolutely nothing for their tenants; why repair structures about to be torn down? It is on the stoops of these disintegrating horrors that any passer-by can see pushers, pimps and prostitutes plying their trades at all hours of the day and night.

Grim evidence confirms the fact of marijuana smoking by teenagers at the lovely, almost new grammar school just a block away. While making my daily rounds, I came to recognize Rosita. Her parents and all her numerous siblings lived packed into one of the ante-bellum flats just mentioned. Her father had been a steward on a ship. Arthritis had felled him and he had to go on relief. In a manner no longer recalled, he had found his way to my office. I had given him some treatments (for free of

* The Case of the Devil's Mercy, *JISMA* 54:11, Nov. 1961, pp. 1652-1659.

course) ; I had also steered him to the OPD of a nearby municipal hospital that he began to attend regularly.

Over several years, I had been asked to attend various members of the Robles household. That is how I had had the opportunity of watching the unfolding of this tenement rose, this orchid of the alley. Her dusky beauty unfolded rapidly as she attained her menarche. Lack of soap and ragged raiment could not keep the young men away from her stoop.

Early one morning, I was hailed by the girl's father, "Doctor; me wait to see you drive out of the garage; not me: Rosita! She very sick; please, stop and look at her!"

It was still only 6:00 a.m.; leaving the car by the curb, I followed him up the dirt littered, dank, dark steps; we went down the dim hall lit by a solitary 15 watt bulb. The stench of human excrement we disregarded; a big, fat rat I did kick out of the way. I was wearing heavy shoes and was not concerned about having the rodent bite me.

An Apathetic Adolescent

Rosita was lying listlessly in bed; the 11-year-old brother who usually shared that bed had been dispossessed. She did not *seem* ill enough to warrant all the concern being shown. Three weeks earlier she had had German measles from which she seemed to have recovered without any complications. She had looked feverish but the school nurse had taken normal readings twice that very week. Still, the usual bounce and vivaciousness that WERE Rosita was just absent! And then, the previous evening, Rosy had vomited her supper and had almost wept with a severe headache unrelieved by several aspirins.



Bedside examination was all on the mundane side. There *was* a reddened throat; there *were* a couple of post-cervical glands; the neck did seem a bit less supple than expected. However, the eye-grounds and ear drums were perfectly OK. The heart and lungs were impressive by their serene normalcy. The abdomen was soft; the liver, spleen and kidneys were not palpable; there were no tender spots even if the bowel sounds were louder and more persistent than one would expect. Really, I had no provable logical reason for my next action. Maybe, it was the clinical experience—the established conditioned reflexes—that I mentioned in the my opening paragraph.

Turning to the parents, I said in my most prosaic manner, "You know, I don't believe that Rosita has really gotten over her measles. It might be safer for me to have one of you come along while I take her to the hospital where I am an attending. It is not in this district but I do not believe that anyone would fuss on that score. That way, I'll be able to keep an eye on her personally."

And that is how Rosita and her mamma found their way to the emergency room of the hospital. Over the scepticism of the intern, she was admitted to the female medical ward as a "suspected meningitis." On the ward, both the medical intern and the resident were impressed by the apathy; also, the nuchal rigidity, by now, was becoming quite definite; the Brudzinski sign was questionably positive. We did a spinal tap. The pressure was up even if not much. The fluid was clear but it did have a gross xanthochromic tinge. Protein was at the upper limit of normal AND sugar was indubitably depressed! Although the cell

count was only 20, they were all lymphocytes. A tube of the fluid was allowed to stand; a *pellicle* formed! Our chief pathologist himself did an acid fast smear of the stuff: no less than two mycobacteria were found quickly!

Blight on the Bloom of Youth

Of course, this last was just a lucky happenstance. Still, we did *not* have to wait for the cultures and guinea pig inoculations to prove the diagnosis: TUBERCULOUS MENINGITIS!

Rosita was the fourth proven case of the week! Maybe, the earlier three had raised my index of suspicion. Anyhow, she was lucky in having been diagnosed in the very earliest, clinically recognizable form of this once universally lethal and still most dreaded complication of the WHITE PLAGUE!*

The spinal tap did much to relieve Rosita's headache. We put her on the porch and halfway isolated her. She was started immediately on streptomycin, one gram i.m. daily; INH (isoniazides), 0.1 gm. t.i.d.; also, PAS (para-aminosalicylic acid), 4 gm. t.i.d. Her blood count was never very aberrant. The chest x-rays were totally normal. The Rosenthal tine test was doubtfully positive. However, we did another spinal tap two days later and had the fantastic luck of getting another pellicle from which acid-fast mycobacteria stained out. A fishing test—an intravenous pyelogram—gave us the unexpected finding of a left hydronephrosis that the urologist wanted to check further for possible tubercles.

We were more than gratified to see Rosita snap out of her lassitude by the end of the very first week of therapy. Her face resumed its usual animation; she watched TV and read voluminously. Also, she became concerned about the school work that she was missing. And, the visitors! It was really hard to keep the teenage boy friends out!

The whole Robles family was dragged into the nearest tbc clinic and checked over for possible contacts. Surprisingly, the Rosenthal tine tests† of the entire family proved negative. So did chest x-rays and all the usual laboratory work-ups. So: where did Rosita get her germs? That problem was in the lap of the Board of Health; I

* Tuberculosis has been on the decrease but in 1963 there were no less than 50,000 new cases of this infectious disease reported in the U. S.. *Reader's Digest* for June, 1964, has a clear warning for the general public of the menace still presented by this infection. The medical practitioner can get an intelligent summary in such a volume as Cecil-Loeb, (11th ed., pp. 312-314).

There is an elegant discussion of tuberculous meningitis in the March, 1964, issue of *Soviet Medicine* (Vol. 27, pp. 53-59). Dr. I. E. Sorkin summarizes his experience with 431 cases. Essentially, he appeals for a greater awareness of the *early* stages of the disease: the prodromal phase that can last from a few days up to a month. This author inveighs against the casual diagnosis of "grippe," upper respiratory infection or what have you. A spinal tap is a simple maneuver that will often lead to the correct diagnosis. Early institution of triple therapy will produce a recovery rate of over 90%. This compares with the 100% mortality prevailing before the discovery of streptomycin, INH and PAS. In 80% of his patients there was a primary pulmonary focus; some 15% had genitourinary tuberculosis. As an editorial member of the translation board of FASEB, I had the pleasure of requesting that the article be translated into English.

Tuberculosis in Children (Edith Lincoln & Ed. Sewell, McGraw-Hill) is a compact monograph in which the authors distill the essence of their vast experience at Bellevue Hospital. The chapter on "Tuberculosis of the Meninges and The Central Nervous System" runs only from pp. 161 through 183. Frankly, I was amazed to read that, in Dr. Lincoln's opinion, some cases of the serous type can recover without being subjected to any treatment whatever

Regardless of the exceptions, all the authorities agree that, once the diagnosis of tuberculous meningitis has been made, therapy must be initiated at once and continued for *years!* Relapses must be avoided by dogged perseverance and insistence on the triple therapy even when the patient appears to be entirely well, clinically speaking.

† S. R. Rosenthal originated this elegantly simple test; the tines are manufactured by Lederle. The four prongs are pressed into the tautened skin of the forearm for a full second; the disposable unit is then thrown away. At the end of three days, the areas of induration are measured accurately in mms If there is any confluence, the test is read as positive. It is much cheaper than the more cumbersome Mantoux test; it is easy, simple and reproducible. By itself, the tine test is inadequate. However, it is a warning flag calling for action.

was pleased no end to see Rosita bounce back so rapidly. It became harder and harder to insist on continuing hospitalization for this seemingly completely healthy girl. We had never started her on steroids even if many authorities believe that these anti-inflammatory agents are a must in tuberculous meningitis.

Love is Like a Rose, the Joy of all the Earth

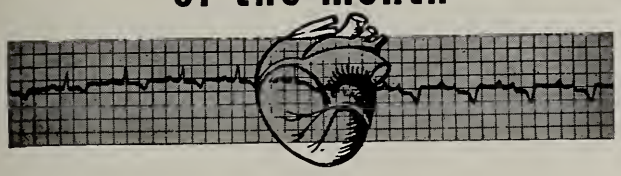
By sort of assuming responsibility for her faithful adherence to the regimen of therapy laid out, I was enabled to get the young lady home much sooner than is customary. I do believe that she has been taking her INH and PAS daily in the dosages prescribed.

A couple of months later, on a hot, sultry summer evening, I passed by the stoop on which Rosita was seated, a young man was holding the hands of my tenement rose; one could sense his soulful look. They were humming softly a duet, *A Lilt of Love's Lullaby!* A Te Deum can come crashing from a cathedral choir. Surely, God must hear just as clearly the hum of thanksgiving being whispered by two young lovers! And I thought myself again the young family physician: and I, also, was humbly grateful. ◄

1270 Fifth Ave.
New York, N. Y.



Electrocardiogram of the month



Presented as a regular feature of The JOURNAL, Electrocardiogram of the Month is a series of short talks on cardiovascular diagnosis and treatment, edited by the staff of the Krannert Heart Research Institute, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis.

Ventricular Tachycardia Treated With Countershock

CHARLES FISCH, M.D.
Indianapolis

A 58-YEAR-OLD MAN was admitted to the Robert Long Hospital because of a ventricular tachycardia of 10 days duration. The arrhythmia began on 5-8-64. The case history disclosed that the man had suffered a myocardial infarction in January, 1964, from which he made an uneventful recovery.

The electrocardiograms reproduced in Figure 1 show that the tracing at the time of initial myocardial infarction (1-30-64) revealed a QS pattern in leads V1, V2, V3, V4 with elevation of the ST segment in leads V2, V3, V4, V5 and V6, indicative of acute massive anterior infarction. A tracing taken on 2-17-64 reveals residuals of the myocardial infarction.

The tracing taken on 5-18-64 shows aberrant intraventricular conduction with a rate of approximately 150. No definite P waves are discernible. A repeat tracing on 5-19-64 again shows aberrant intraventricular conduction and this time definite P waves are visible (these are independent of the QRS complexes). This arrhythmia did not respond to quinidine or pronestyl. The patient was then taken to the catheterization laboratory where one countershock reverted the arrhythmia to normal sinus rhythm with the residuals of anterior myocardial infarction (5-19-64). ◄

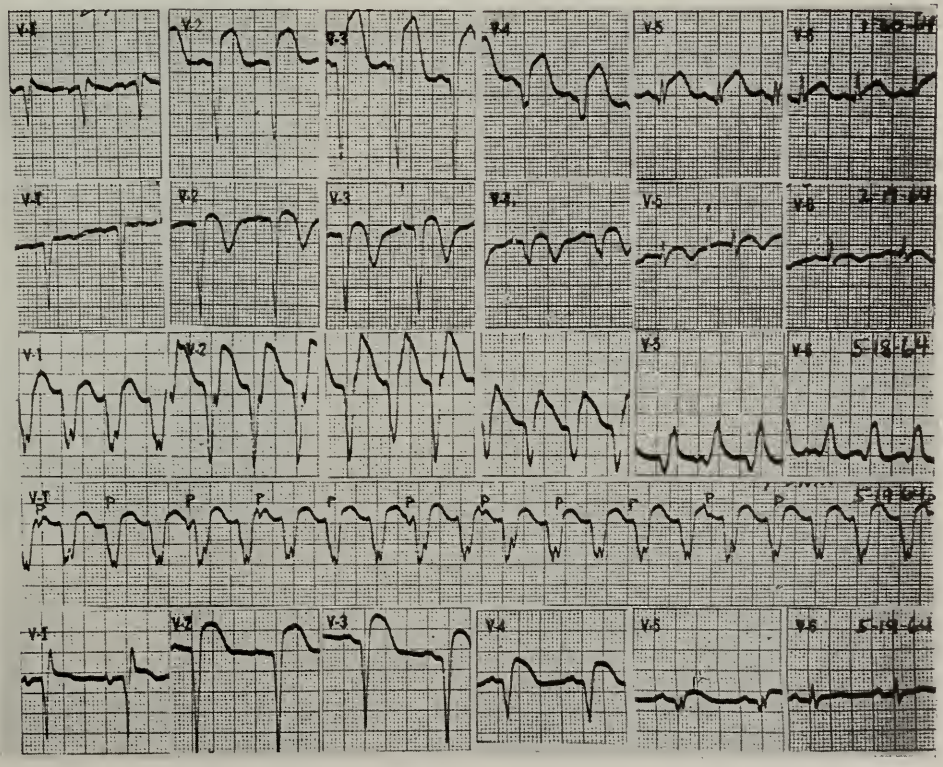


FIGURE 1
THIS TRACING shows an acute myocardial infarction in the top row with evolution of the infarction in the second row and ventricular tachycardia in the third and fourth rows. The bottom row was recorded after countershock showing normal sinus rhythm and residuals of anterior myocardial infarction.

X-RAY CONFERENCE

Presented as a regular feature of *The Journal*, X-ray Conference is a series of short talks on procedure and radiologic diagnosis, edited by Erich K. Lang, M.D.

Hydronephrosis of the Right Kidney

*ERICH K. LANG, M.D.**
Indianapolis

A SIX-YEAR-OLD white boy was admitted with the complaint of an increasing mass in the right abdomen. Progressive enlargement of the right half of the abdomen had first been noted some four months prior to admission. The area, however, was not tender nor did the patient complain of any pain. In view of the lack of tenderness and absence of pain, the parents had disregarded the formidable mass for this long period of time.

At the time of admission a large football sized mass bulged the right abdominal wall. The umbilicus was flattened out. The mass was quite firm, showed no fluid wave transmission and could not be moved freely. There was no tympanitic resonance or tenderness to percussion and no tenderness to palpation. An upper GI series and a barium enema revealed displacement of large and small bowel into the left abdominal cavity. Even the root of the mesentary of the ascending colon appeared to be displaced towards medial suggesting that one was dealing with a huge retroperitoneal mass.

A retrograde pyelogram of the right kidney revealed marked deviation of the right ureter across the midline to the left side. The dye in the pelvis of the right kidney was markedly diluted; however a huge hydronephrosis was well demonstrated despite the dilution.

Exploration via a transabdominal approach revealed a huge hydronephrosis of the right kidney. More than 5,000 cc. of urine were evacuated from the kidney pelvis. The parenchyma of the right kidney was paper thin, forming a huge sac with the pelvis along its medial border. The removal of this sac-like kidney structure posed no difficulty.



FIGURE 1

NOTE THE MARKED medial displacement of the right ureter across the midline to the left side. There is marked dilution of the dye reaching the right kidney pelvis, however one can see the shadowy outline of a huge sac-like structure. The intravenous pyelogram failed to show any dye excretion on this side or any opacification of this huge sac-like structure. (Photographic reversal in positive print).

* Radiologist, Methodist Hospital.

Discussion

The differential diagnosis of mass lesions of the abdomen in infants includes tumors of the kidney, the suprarenal gland, cysts of the kidneys, hydronephrosis of the kidneys, intra-abdominal tumors, reduplication cysts of the large and small bowel and intra-abdominal cysts of other etiology. The prevalence of certain entities in set age groups helps to differentiate these masses. The clinical and radiographic appearance of intraperitoneal tumors is usually readily distinguished from retroperitoneal tumors.

Neuroblastomas and embryomas of the kidney will usually show marked distortion and displacement of the pelvocalyceal system but are distinguished by near normal dye concentration in the calyces and pelvis on the intravenous pyelographic examination. Cysts of the kidneys are, likewise, best demonstrated on intravenous pyelograms and show classical splaying of the pelvocalyceal structures with near normal dye excretion and concentration on intravenous pyelograms.

Conversely, a massive hydronephrosis is usually distinguished by a non-functioning and non-visualizing kidney. The absence of calcifications within the mass, the failure of dye excretion on intravenous pyelograms, marked displacement of intra-abdominal structures (even the mesenteric root) and a relative lack of clinical symptoms in spite of a huge rapidly enlarging mass, usually suggests the presence of a hydronephrosis of the kidney. ◄

From *The Journal* 50 Years Ago

. . . To be the family doctor is a stewardship most serious, responsible and honorable, and should foster the most painstaking, vigilant and constant efforts of every conscientious physician. He should be polite, prudent and honest and must not give offense by being abrupt or brusque when in a hurry or fatigued. While he must possess a certain amount of dignity, he must not be dignified or aristocratic. He should take an active part in everything that may have an elevating influence on the community in which he lives, especially in matters pertaining to the public health and morality.

* * * *

The honor of the medical profession has been built up, and can be maintained, only by men of honor; men of principle and conscience, loyal to its purpose and ideals. It is quite as important to think of what we should give to the profession, as it is of what we hope to get out of it. There is no need of an elaborate code of ethics; the Golden Rule is all-sufficient for every emergency, and is so easily memorized that there can be no ground for pleading ignorance.

* * * *

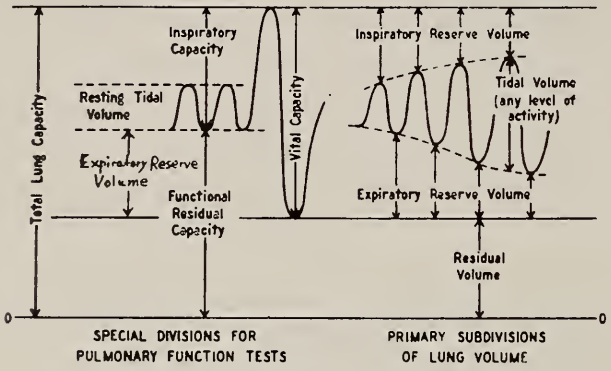
Finally the family doctor must keep up with the progress of the times. He must know what is going on in the line of investigation and improved methods of treatment. He must procure new textbooks at frequent intervals, take several prominent medical journals and be a member of his local and state society. He should have a microscope and other accessories necessary to make his diagnosis as complete as possible. If he attends to his business and to the advancement of his abilities as he should, he will find no time to loaf and will never die of ennui.—Eugene G. Regennas, M.D. "The Family Doctor", *JISMA*, October, 1914.

Path-finder
PUBLISHED UNDER THE AUSPICES OF THE INDIANA ASSOCIATION OF PATHOLOGISTS

Pulmonary Function Tests (Part II)

WEI-PING LOH, M.D.*
Gary

THE VARIOUS SUBDIVISIONS of lung volume are shown below and their relation is affected by many disease processes.[3,4]



A properly recorded spirogram offers correct measurements of the following items[5,6]:

(1) *Inspiratory Capacity* (IC) is the maximal volume that can be inspired from the end-expiratory level.

(2) *Expiratory Reserve Volume* (ERV) (supplemental air) is the maximal volume of air that can be expired from the end-tidal expiratory level.

(3) *Forced Vital Capacity* (FVC) is the sum of IC + ERV. It is maximal volume of air that can be expired after a maximal inspiration.

(4) *Rate and regularity of respiration.*

(5) *Tidal Volume* (TV) is the volume of air or gas during each respiratory cycle.

(6) *Functional Residual Capacity* (FRC) is the volume of air or gas remaining in the lungs at the resting expiratory level.

(7) *Residual Volume* (RV) is the volume of air or gas remaining in the lungs at the end of a maximal expiration.

(8) *Supine Vital Capacity* (VC) is the vital capacity measured in a supine position.

(9) *Total Lung Capacity* (TLC) is the amount of air or gas contained in the lungs at the end of a maximal inspiration.

Normal individuals of similar age, sex and stature may deviate as much as ±20% from their predicted values.[7] The inspiratory capacity usually amounts to 75% and expiratory reserve volume 25% of the vital capacity. The expiratory reserve decreases with paralysis of muscles used in expiration (abdominal muscles and diaphragm). An increase in expiratory reserve and a decrease in inspiratory capacity may be seen with hyperinflation of the lung (bronchial asthma, obstructive emphysema).

The vital capacity and inspiratory capacity are normally reduced in older age groups. Reduction in vital capacity as an isolated finding is termed a "restrictive ventilatory defect" which may be caused by: (1) replacement, obliteration, compression, or collapse of lung tissue by tumor, fluid, inflammation, or fibrosis (bronchogenic carcinoma, pleural effusion, interstitial fibrosis, heart failure, thoracoplasty, bronchiectasis); (2) expiratory air trapping (lung cysts with poor bronchial communications, asthma, obstructive emphysema); (3) loss of mobility (rheumatoid spondylitis) or muscular force of the respiratory apparatus, preventing expansion or contraction of the thorax (poliomyelitis, kyphoscoliosis).

* Chief Pathologist, Methodist Hospital of Gary; Assistant Professor of Pathology, Chicago Medical School.

Serial determinations of vital capacity are usually needed in evaluating therapy and following the course of disease. Changes greater than 200 ml on repeated determinations can be considered significant. Thus, changes in the state of cardiac compensation over prolonged periods of stress and therapy can be defined, the effectiveness of bronchodilator therapy assessed, the progressive deterioration (or improvement) of respiratory muscle paralysis in poliomyelitis evaluated, and the course of ankylosing spondylitis followed by serial determinations of the vital capacity.

Comparison of the vital capacity determined as a single maneuver ("actual" vital capacity) with that obtained by separate determination and addition of the inspiratory capacity and expiratory reserve volume ("combined" vital capacity) yields useful information.[7] Normally, the "actual" and "combined" vital capacities are the same. When the combined vital capacity exceeds the actual capacity, air trapping is certainly present. The discrepancy, which may be as great as 1 L, represents the volume of air trapped. The phenomenon is seen in obstructive emphysema, and may be of aid in the early diagnosis of this disease. It can also be seen with bronchospasm or bronchial secretions from any cause (bronchial asthma, bronchitis). Poor cooperation or malingering should be suspected if the actual exceeds the combined vital capacity in any significant amount.

The degree of reversible air trapping due to bronchospasm (bronchial asthma) and that due to irreversible causes (elastic tissue degeneration in obstructive emphysema) may be measured by determining the increase in vital capacity after the administration of bronchodilator drugs.

In addition to "air trapping", examination of the spirogram can also detect "respiratory neuroses." Patients with anxiety neuroses may display an irregular, shallow type of respiration, with frequent changes in resting end-expiratory position. Subjects with conversion hysteria are noted for their frequent deep, sighing respirations and, in severe cases, may hyperventilate to the point of alkalotic tetany during their initial experience with spirometry.[7,8]

A. *Maximal Voluntary Ventilation (Free) (MVV_F)*:

The maximal voluntary ventilation measures the greatest volume of gas that an individual is capable of breathing voluntarily per unit time. This is usually measured during a 15-second period of effort and the result expressed in liters per minute. The determination of it is the one single test that evaluates the overall integrated function of the ventilatory apparatus. The usual practice is to consider $\pm 20\%$ of the normal predicted value as the normal range.

The finding of a normal MVV_F is strong evidence against pulmonary disease as the cause of dyspnea. The exception to this statement is found in the alveolar-capillary block syndrome and in diffuse pulmonary vascular disease where, in the face of severe dyspnea with the slightest exertion, the MVV_F more often than not is maintained at normal or near-normal levels. The normal MVV_F depends on freely mobile thoracic structures, normally functioning respiratory muscles, patency of the tracheobronchial tree offering the least resistance to air flow, ability of the lung tissue to be stretched and deformed rapidly with the least work, delivery of a maximal stroke volume (tidal volume per breath) equal to at least one-half of the predicted normal vital capacity, and coordinated activity of the neuromuscular forces. Assuming maximal cooperation and voluntary effort, and the absence of severe debility or other disease, the MVV_F may be reduced in the following conditions:

(1) Immobility of the skeletal system (rheumatoid spondylitis, senile emphysema, kyphoscoliosis).
(2) Loss of respiratory-muscle force (poliomyelitis, myositis, myasthenia gravis).
(3) Obstruction to air flow (bronchial asthma, obstructive emphysema, bronchitis with bronchospasm, tracheal or bronchial tumor).
(4) Stiff or immobile lung tissue (diffuse, parenchymal fibrotic processes, massive pleural effusion).
(5) Extreme reduction in vital capacity from any cause so that an increase

in respiratory frequency cannot compensate for reduction in stroke volume.

(6) Un-coordinated neuromuscular forces; these are not commonly recognized as such, but are sometimes found in obstructive emphysema and bulbar poliomyelitis.

The test finds its greatest use in diagnosing and following the course of obstructive emphysema and in preoperative evaluation for thoracic surgery. In the latter connection, an MVV_F of less than 40 L/min in the male patient usually indicates a poor operative risk for thoracic surgery. A cooperative patient can usually duplicate the MVV_F readings within ±five percent. When MVV_F is reduced to less than 50% of the predicted normal value, dyspnea usually occurs.

B. *Forced Expiratory Volume 1 sec. (FEV_1 and % FVC 1 sec.)*:

This measurement is a part of the timed vital capacity (TVC). Vital-capacity determinations without respect to time give little information as regards the presence of obstructive ventilatory defects. Given enough time, the patient with incapacitating asthma or emphysema may deliver a normal vital capacity. Timing the vital capacity recognizes the fact that the cyclical process of respiration is limited by time.

In this test the subject (fitted with nose clip) is instructed to inspire maximally, then expire as fast and as much as he can. The portion of the total capacity that is delivered in the first second of expiration is determined and expressed as a percentage of the total volume expired. The normal value is 83%.

A reduced FEV_1 (less than 75% of vital capacity in the first second) indicates obstruction to air flow, the commonest causes of which are obstructive emphysema and bronchial asthma.

Administration of bronchodilator drugs will result in an improved FEV_1 in the presence of reversible obstructive ventilatory defects such as bronchial asthma. Patients with restrictive ventilatory insufficiency (reduced lung volume due to massive effusion, fibrosis, etc.) are still capable of delivering the normal timed fractions in the absence of obstruction to air flow.

C. *Alveolar Ventilation ($\dot{V}_A$)*:

That portion of each tidal volume which reaches the alveoli to participate in gas exchange is equal to the tidal volume (TV) minus the volume expended in the dead space V_{DS} (estimated), and this difference TV - V_{DS} multiplied by the respiratory frequency is equal to the minute alveolar ventilation. Normal figures are 1.5-3.5 L/min m^2 or 4,200 ml/min for resting adults.

The term alveolar hypoventilation indicates that the volume of inspired air reaching the alveoli is insufficient to oxygenate pulmonary capillary blood adequately and rid it of its carbon dioxide. This can result from uncompensated decreases of tidal volume or respiratory frequency, increased dead-space effect, or abnormalities of the distribution of inspired air. The result is unsaturation of arterial blood and carbon dioxide retention with respiratory acidosis (confirmed by CO_2 and pH determinations).

The term alveolar hyperventilation indicates excessive alveolar ventilation. This results in lowering of the carbon dioxide pressure of the blood and a nearly proportional loss of carbon dioxide, which results in respiratory alkalosis. The oxygen pressure of the alveoli and arterial blood is increased.

Alveolar hyperventilation with respiratory alkalosis is seen commonly in anxiety states (the hyperventilation syndrome) and during artificial respiration, for instance, in poliomyelitis or during anesthesia, where the patient may be "overbreathed." Occasionally, prolonged hyperventilation is seen as a sequel to encephalitis, head injuries or intracranial operations.

D. *Forced Mid-Expiratory Flow (FEF 25 - 75% VC)* is the mean rate of flow (in L/min) for the middle 50% of a maximally rapid vital capacity maneuver. For a normal adult, this measurement should go above 100 L/min. This measurement is largely independent of effort and is showed in the presence of obstruction of the small airways.

E. *Forced Expiratory Flow (FEF)* is determined from the time required to

rapidly exhale the one liter of air from the 200 cc. to the 1,200 cc. volume. It is recorded in L/min. This measurement is particularly affected by obstruction of the large airways, is effort-dependent and is particularly responsive to bronchodilatation.

F. *Peak Expiratory Flow* (*PEF*) is determined by exhaling air rapidly into a Wright peak flow meter. For a normal adult this measurement should go above 300 L/min (usually 530 ±50). Close agreement should exist between the PEF and the MVV.[9,10]

G. Air Velocity Index

$$\left(\frac{\%\text{ of predicted MVV}}{\%\text{ of predicted FVC}}\right)$$

is used to differentiate between restrictive and obstructive defects. The normal range is 1.0 ± 0.2.

H. *Minute Volume* (*MV*) is the volume of inspired air that passes through the nose and mouth per minute (respiratory rate x TV).

I. *Oxygen Consumption* is the volume of oxygen absorbed by the lungs in one minute.

J. *Ventilatory Equivalent* (*VE*) *for* O_2 is the volume of air breathed per 100 cc. of oxygen consumption. It is normally above 2.5 liters.

K. *Walking Ventilation* (*two mph*) (*WV*) is the volume of air breathed per minute when walking slowly on the level at the rate of two miles per hour. It is normally 9 ± 1 liters/min/M^2.

L. *Walking Dyspnea Index* (*two mph*) (*% of MVV*): WV/MVV x 100. It is normally below 15%.

M. Additional tests generally available include helium equilibration time (intrapulmonary mixing), diffusion and perfusion evaluation, bronchospirometry, blood gases and pH determinations, etc.

Tests A, B, C, E, F, and G are generally repeated after inhalation of Isuprel, a bronchodilator drug. In order to interpret the test results accurately, one is required to know the patient's history, physical findings, chest x-rays, fluoroscopic findings and other laboratory findings including red blood count, hematocrit, circulation times, electrocardiogram, etc.

The commonly used pulmonary function tests are summarized below.

Reporting form of pulmonary function tests

W. P. Loh M.D. TELEPHONE 883 6661

PULMONARY FUNCTION TESTING
METHODIST HOSPITAL OF GARY, INC.

Lab. No.____

NAME_____ REFERRING PHYSICIAN_____

ADDRESS & TEL.NO._____ TENT. DX. _____

AGE___ SEX___ Wt.(kg)_____ Ht.(cm)____ BSA (M^2)____ X-Ray___ Hist.____ Fluor._____

I. SPIROMETRIC MEASUREMENTS	PREDICTED	OBSERVED No Drugs	OBSERVED After Isoprot.	% PREDICTED No Drugs	% PREDICTED After Isoprot
Max.Voluntary Ventilation (L/min) (MVV_P)					
Forced Vital Capacity (L_4) (FVC)					
Forced Expiratory Vol.1 Sec.(FEV_1)					
Forced Expiratory Vol.(% FVC 1 Sec)	>75%				
Forced Mid-Exp.Flow(FEF 25-75%)25-75% V.C. (L/min.)					
Forced Expiratory Flow(FEF 200-1200)(L/min)					
Peak Exp.Flow (L/min) (Wright)					
Air Velocity Index MVV% Predicted / FVC% Predicted	1.0 ± D.2				

II. LUNG VOLUMES	PRE-DICTED	OB-SERVED
Total Lung Capacity (ml) (TLC)		
Vital Capacity (ml) (V.C.)		
Inspiratory Capacity (ml) (IC)		
Expiratory Reserve Vol.(ml) (ER)		
Functional Residual Cap.(ml)(FRC)		
Residual Volume (ml) (RV)		
RV/TLC x 100 (%)		

III. VENTILATION I. Basal	Normal	Patient
Respiratory Rate/min.		
Tidal Vol.(ml) (TV)		
Minute Vol.(ml)		
Oxygen Consumption		
Vent.Equiv.for O_2 (L/100 ml)	2.5	
Alveolar Vent.(ml/min)		
VENTILATION-II.Exercise		
Walking Vent. (2 mph) (L/min/M2)(WV)	9±1	
Walking Dyspnea Index (2 mph)(%ofMVV)WV/MVVx100	15%	

IV. DISTRIBUTION - Intrapulmonary Mixing	Normal	Patient
Helium Equilibration Time(min.)	1.5	

V. Others

INTERPRETATION (over)

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(To be continued).

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

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Another Milestone

18th Clinical Meeting of the American Medical Association

IN THE American Medical Association's long history of fostering the continuing education of practicing physicians, the 18th clinical convention next November 29-December 2 in Miami Beach marks another milestone.

An excellent scientific program has been planned for the meeting. Particularly noteworthy is the postgraduate course on obstetrics, consisting of a comprehensive series of lectures by outstanding teachers.

Other sessions are devoted to timely subjects of wide interest and will be followed by question and answer or discussion periods. The fireside conferences and breakfast roundtables will provide further time for informal discussion.

There is today an acute awareness of the need for continuing education throughout the medical profession. Much effort is currently being exerted to provide better educational opportunities for practicing physicians. Yet learning obviously remains an individual matter which rests on the personal initiative of each physician.

Every physician who possibly can should take advantage of the educational opportunity represented by the clinical convention.

Diabetes Detection Week

THE NORMAL DAY-TO-DAY search for new diabetic patients will be intensified and publicized this year by observance of Diabetes Week from November 15 to 21.

Thousands of previously unknown diabetics have been detected during Diabetes Detection Week in former years. It is estimated that there are constantly about as many unknown diabetics as there are known ones (the passage of time presumably adds to the host of unknowns). The detection program adds to the list of *known* diabetics, so that as the special Diabetes Week rolls around each November, a fresh supply of candidates emerges to add to the ever increasing membership.

Feelings of fellowship are the smallest part of the welcome which a newly discovered diabetic patient receives. Rewards of fewer complications and more easily managed treatment accrue to the person whose diabetes is diagnosed early in its

course. Uncontrolled diabetes is so damaging as to make early discovery, earlier by even a few days, well worthwhile. It would not be fantastic to wish for a special detection period every week during the year, in order to increase the dividends which are realized by those who are able to take advantage of proper treatment soon after their diabetes becomes diagnosable.

The American Diabetes Association and all its affiliates, together with medical societies all over the United States, will work with leaders of business, industry and labor, and with pharmacists, teachers and service clubs in publicizing the aims and methods of the detection drive.

Survey of Hospital and Medical Care

MINUTES of the Joint Committee for the Improvement of Patient Care in Indiana contain an extraordinary amount of information in regard to hospitals and medical care. Dr. Joseph B. Davis, Marion, chairman of the committee has made available to ISMA a report on the Veterans' Administration medical service.

The report is in the form of a presentation by Dr. Verne K. Harvey, Sr., sometime Medical Director of the Civil Service Commission and more recently and now retired as Director of the Veterans' Administration Hospitals in Indianapolis.

Dr. Harvey stated that the Veterans' Administration maintains 169 hospitals and 18 domiciliary institutions. There are 120,000 hospital beds in the VA hospitals and 5,000 beds are available for veteran care in other government hospitals. The hospital occupancy rate is around 113,000. Approximately 25,000 veterans reside in domiciliary facilities.

Medical care is divided into medical, surgical and psychiatric services. There are 41,000 medical beds, 20,000 surgical beds and 59,000 psychiatric beds. Psychiatric beds constitute a large part of the hospital service since these cases require much longer hospitalization.

To be a beneficiary of the VA, a person must have been a member of the Armed Forces in war time. There are approximately 22 million who qualify; 22,000 from the Spanish American War, 2.3 million from World War I, over 15 million from World War II and about 5 million from the Korean War.

The average age of all war veterans is 44 years. By wars the average age is: Spanish American, 85.3; World War I, 69; World War II, 44 and Korean War, 33 years.

There are a total of 727 beds in the two

Miami Beach Plays Host To AMA Clinical Convention

A scientific program attuned to the current needs and interests of the practicing physician is planned for the 18th clinical convention of the American Medical Association.

Immunization, depression, cardiac arrhythmias, vascular occlusive diseases, emphysema, iatrogenic diseases and hypertension are only a few of the major areas to be explored during the four-day meeting, Nov. 29-Dec. 2.

More than 300 physicians will participate in a full program of lectures, exhibits, motion pictures, color television, fireside conferences and breakfast roundtables.

A new feature of the clinical convention this year is a postgraduate course on obstetrics for the general practitioner. Fifteen lectures will be presented during three sessions ranging from infertility and prenatal care through complications of labor and anesthesia to postnatal care and maternal mortality.

The entire scientific program, with the exception of the fireside conferences and breakfast roundtables, will be held in Miami Beach Convention Hall. The modern, single-level structure, completed in 1959, is fully air-conditioned and boasts one of the finest sound amplification systems to be found anywhere in the nation. It is located just one block from the Lincoln Road shopping center, Florida's Gold Coast and the ocean.

The popular fireside conferences, presented as a joint session of the American College of Chest Physicians and the AMA, will be held Sunday night, Nov. 29, at the Fontainebleau Hotel. There will be 11 tables at which 50 to 60 discussion leaders will engage in an informal and free exchange of views on a variety of medical subjects.

Six breakfast roundtables are scheduled at the di Lido Hotel. Topics include cancer of the thyroid, cosmetic surgery and peptic ulcer. In addition, 125 scientific exhibits will be on display during the meeting, including a special exhibit on fractures, and some 30 medical motion pictures will be shown in the afternoon Monday through Wednesday.

VA hospitals in Indianapolis. The two hospitals are administered as one; 417 beds are devoted to medical cases. This includes 115 beds for tuberculosis, most of which are at the Cold Springs Road Hospital. One hundred ninety-five beds are surgical, 78 psychiatric and 37 neurologic. Indiana also has two other VA hospitals, at Fort Wayne and Marion, which are devoted primarily to psychiatry.

During the past fiscal year the cost per patient-day was $27.86. This is composed of $19.41 for patient care, $3.78 for food, $1.17 for housekeeping, 41 cents for laundry, $1.52 for engineering and operation and $1.57 for maintenance and repair. Eighty-five cents of every dollar spent by the hospitals is spent for wages and salaries.

The needs for blood for transfusion, approximately 4,000 pints per year, are furnished by volunteer prisoners of the State Penal Farm, the Indiana Reformatory and the Federal Prison at Terre Haute. Inmates of these penal institutions are surprisingly enthusiastic about the opportunity to donate blood for therapeutic uses.

The VA hospitals in Indianapolis are affiliated with Indiana University School of Medicine and are medically supervised by the dean's committee. Medical students, nurses, interns and residents at the I.U. Medical Center usually are on services which rotate through the VA hospitals.

One-half of all the nation's new doctors receive some of their training in Veterans' Administration hospitals.

Dr. Harvey pointed out that, while the full-time physicians of the VA system could and were urged to do research, all research was done on the doctors' own time. Despite this rule, much research of a practical and clinical nature is carried on.

Dr. Harvey also emphasized one of the characteristic activities of the VA staffs was the conduct of intramural training and safety programs. These deal with the security of drugs; the proper disposal of disposable syringes and similar equipment to prevent unauthorized or illegal use later; the prevention of accidents to patients and staff; the prevention of fire and the organization of the entire hospital for emergency and disaster situations.

The trend in clinical medicine is marked now by the decrease in the need for inpatient facilities for treating tuberculosis, and by the tendency to treat psychiatric patients in general hospitals in nursing-home type surroundings.

Guest Editorial

Nation Fights Novotealysis

LEADERS IN AMERICAN MEDICINE are again warning Americans against a possible epidemic of *novotealysis*, a condition which affects many adult Americans. Although vast sums have been spent on research and education since the last great outbreak in 1960, a possibility of a flareup is always present. Because of the nature of this peculiarly American disease (of which too little is known), it can appear in many areas at the same time. Although of short duration, the epidemic often leaves the nation with serious after effects.

During the past four years, the study showed that *novotealysis* is no respector of personalities, as it strikes at all levels of the nation's income groups. However, a large number of cases occur among members of the professions, with doctors of medicine being among those often afflicted.

They have also determined that the disease attacks both males and females, beginning at the 21-year-old level, although two states reported cases among 18-year-olds.

The etiology of *novotealysis* remains obscure, although recent accounts in the literature point to such factors as organic apathy and psychological indifference. Advances such as these are encouraging, since each and all of these factors should respond to current available medications.

Both temporary paralysis of the hand and loss of forward motion of the feet characterize the disease. Strangely enough, the diagnoses have been more readily made by political observers than by busy men of American medicine.

Treatment thus far has been confined to certain groups using programs that stimulate higher centers that supposedly rejuvenate the interest and perceptive powers of the brain.

Probably the best hope for a quick and speedy cure to this disease lies in the area of preventative medicine. Only prevention will stop the shocking sequelae which most assuredly influence the general well-being of affected and unaffected offspring.

It is hoped that members of the profession will alert themselves to early recognition of this disease, and will hasten their patients to the polls for prompt initiation of therapy.

The implications of the above allegory are many. To the practicing profession, it is both a challenge and an indictment. To the medical student, it can mean just one thing —the development and use of the strongest antibiotic known to politics—the individual doctor's vote.

Only when physicians-to-be and physicians-who-are accept their full and complete responsibilities of American citizenship, can there be hope of relief from the ravages of *novotealysis*—a disease welcomed by self-perpetuating politicians to the detriment of the people at large. Don't hazard the loss of the vital function characterized as voting. Failure to use it results in permanent atrophy.—Russel F. Staudacher, reprinted from *The New Physician*, Oct., 1964.

Editorial Notes...

Mead Johnson & Company is protesting a press release by the Food and Drug Administration to the effect that an improved mixture of cream and milk recently marketed in canned form is a new drug. The preparation, named "Quell," is labeled as a special dietary food and is dispensed in six ounce cans for use as a component of a modified "Sippy diet." Mead Johnson is objecting to the widespread public release of the FDA ruling without prior notification to the company; and also to the ruling that a time-honored dietary preparation should be called a new drug simply because it is dispensed in a can.

The fiberglass pole has elevated pole vaulters to new heights but at a cost. Each pole is engineered in manufacturing to support a certain load, but is dangerous if overloaded by as much as five pounds. Each athlete must be provided with a pole made especially for his weight, or there is danger of breakage with awkward falls and possible impalement. Authority: AMA Committee on Medical Aspects of Sports.

The Indianapolis Speech and Hearing Center inaugurated a Dial-A-Hearing Test in May and has received a tremendous response as a result of only one newspaper announcement. By dialing ME. 4-2883, the listener is connected with a two-minute hearing screening test. The initial response has prompted the continuance of the service for six months and possibly for a year.

The American Medical Association is sometimes accused of exceeding the bounds of propriety in its appropriation for lobbying expenses in Washington. *The Congressional Quarterly* recently published the expenses for 1963 of the largest lobbying organizations. The AMA is listed at a modest $57,233. This amount is exceeded by ten organizations, six of which are unions. The American Legion, the Savings and Loan League, the Business Committee for Tax Reduction and a Committee for Nuclear Test Ban complete the ten big spenders. The organization at the head of the list spent almost three times as much as the AMA; the second organization allocated almost two times as much.

"The Hucksters of Pain," an expose of the quacks who thrive on the fraudulent treatment of arthritis, which appeared in the *Saturday Evening Post* a year ago, has won for its author, Ralph Lee Smith, the $500 Russell L. Cecil Award. The award is given annually by the Arthritis and Rheumatism Foundation for the best story on arthritis. Dr. Cecil is consulting medical director of the Foundation. The award was inaugurated in 1956 to honor Dr. Cecil's 50

years in the active practice of medicine.

It has been recommended that all pregnant women be tested in the prenatal period for irregular antibodies. Hanson and Rutkowski of Toledo reported their findings in a scientific exhibit at the San Francisco AMA convention. In 720 pregnant women, they found 33 with either anti-Rh or other irregular antibodies which could cause erythroblastosis. Twenty-one of the 33 were Rh negative; the remaining 12 were Rh positive with antibodies other than anti-Rh. While the likelihood of erythroblastosis is not as great in the Rh positive patients, the exhibitors feel that the risk is great enough to warrant the screening of all pregnant women, instead of Rh negative cases only, as is now done.

Hospitals are participating in a nationwide program to control hospital costs by comparative analysis. The program is called Hospital Administrative Services and is financed by the W. K. Kellogg Foundation. Hundreds of hospitals are involved in the data collection and each month receive a comparative analysis report on expenditures. One hospital found that it was paying 89 cents a pound for pork chops which another hospital was getting for 48 cents. The supplier of the high-priced chops explained that his chops were from "pigs specially raised for hospitals."

Since 1960, the number of physicians in the U. S. in private practice has increased by four percent—total now 174,974. In the same length of time, the number of physicians not in private practice has increased by 20% to a total of 100,168. "Not in practice" includes interns, residents, full-time hospital staffmen, full-time medical school faculty members and those in administrative medicine, laboratory medicine, research and retired groups. The total number of physicians is up nine percent.

The "unfilled prescription problem" has been settled. Estimates of drugs prescribed but not purchased have run as high as 50%. This inordinately high figure has been due, it is now apparent, to either inadequate surveys or guess work. Study in four Wisconsin communities by a graduate student in the University of Wisconsin School of Pharmacy showed that of 2,019 drugs prescribed, only 3.3% were not dispensed within 10 days. Further research revealed that almost all of the prescriptions were eventually filled, the delay being due to the fact that the medication was not to have been taken until later or that the patient had a supply of the drug from an earlier prescription. In no case was the financial factor mentioned as the cause for delay.

The Boston Floating Hospital for Infants and Children has established several rooms in which a mother may room-in with a child patient. Each room contains a crib or bed for the child, a studio couch for the mother, and a snack-stocked refrigerator, hot plate and toaster for the mother's use. The original object was to lessen emotional upset. This has been accomplished. Children are more relaxed, have better appetites and are more content. Secondary benefit: even though no charge is made for the mother's food, the room rate has been lowered by $5.00 per day. Reason: mothers have done so much of the nursing that the nursing service may be lessened to that extent.

Nine out of ten applicants for enlistment in the U. S. Army are found to be qualified, but only one of every two draftees are found to be acceptable. Natural selection has a lot to do with the difference. Enlistment is voluntary and appeals to young men who are physically capable and mentally alert. Recruiting stations reject some on mental tests before they go to examining stations. Actually the youth of the country is about as qualified for service as they have ever been. The mental standards were raised in 1963, and now, according to peacetime standards, about 32% of men of military age cannot meet the physical, mental and moral standards. Wartime specifications would reject about 27%. At present all the services except the Army obtain their requirements by voluntary enlistment, and the Army obtains 72% of their men in

this manner. There were only 120,000 draftees in 1963, 28% of the Army requirement.

Schizophrenic patients, in large numbers, are being safely returned to community life, sometimes permanently, by the Veterans Administration. A carefully controlled study in 12 VA Hospitals, of which the facility at Marion, Indiana, is one, has shown that ex-patients of this type have a better police record than the average male. Nine out of ten of the patients in the study were discharged during a five-year period. Forty percent required additional treatment within one year; two-thirds required additional hospitalization within four years. Some have returned to full-time employment.

A device developed at Purdue University can be used by doctors to determine from a graph exactly what is going wrong in the gait of a limping person. An electronic mechanism, connected with a treadmill, produces a graph automatically. The graph is diagnostic and may be plotted at intervals to demonstrate efficacy and degree of improvement. The device is being used experimentally at the Crossroads Rehabilitation Center in Indianapolis.

The American Standards Association has recently adopted standard prescription requirements for first quality glass ophthalmic lenses. Previously there had been many versions of "first quality." The National Society for the Prevention of Blindness is commending all manufacturers and fabricators who produce lenses at this standard or better and is urging all others to bring their products up to first quality. The objective is that everyone with glasses should have lenses of first quality.

Foreign citizens, 92,000 strong, were studying, teaching or doing research in U. S. colleges, or training as interns or residents in American hospitals this year. This figure is up from 78,000 reported last year. Interns and residents number 8,804 and come from 100 different countries. Last year we had 7,257 from 90 countries. The Philippines lead the list with 2,108 physicians training here.

The clinical efficacy and desirability of Parnate was dramatically demonstrated during the time it was withdrawn from the market. Smith Kline and French received over 700 letters from doctors in 46 states requesting emergency supplies of the drug for use in some 2,000 patients for whom the medication was practically indispensable. Parnate has been made available again, with new package information which narrows indications, lowers dosage and restricts its use to patients below the age of 60.

A bill has been introduced in Congress to remove from the Immigration and Nationality Act the reference to epilepsy as a bar to entry into this country. It is pointed out that 85% of all persons with epilepsy can be successfully controlled with medication and can do productive work. Epileptics have the same range of intelligence as the general population, and since the condition cannot be inherited, there is no reason to discriminate against those with epilepsy, or to imply any stigma to a person with the disease.

Hospital labor costs have increased 545% since 1946. As is well known, wages and salaries constitute 65 to 70% of all hospital costs. The wage increase has contributed most to the increase of cost per patient-day, from $9.39 in 1946 to $38.91 in 1963. Wage and salary expenditures are up because hospitals have adopted the 40-hour week, are paying wages more nearly comparable to those paid by other employers and because hospital work today requires more highly trained technical personnel. Another factor in the total wage cost is the fact that 241 employees are required today for 100 patients, in contrast to 148 per 100 patients in 1946. Labor costs are bound to increase even further, since hospital wage scales are not yet up to industrial wage scales, industrial wage scales are rising steadily and will influence hospital rates more and more. ◄

President's Page

Rep. Cecil R. King of California (King-Anderson) has as of the moment withdrawn consideration of the Gore Amendment to the Social Security bill.



This is a victory for the working man under Social Security.

This is a victory for the Social Security System, for its survival would have been doubtful had the additional burden been placed upon it.

This is a victory for American medicine, for its protection of the welfare of patients in the socio-economic field — Taxes!

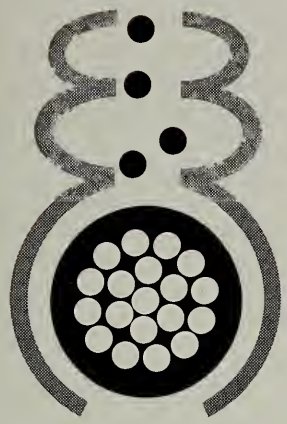
The continued vigilance of the entire country to prevent socialized medicine is essential. The fight is *not* over.

I would appeal to those of you in specialty groups, in general practice, in contract medical practice, medical education —in fact, in every field of medicine—to impress upon your colleagues that if medicine is to serve the public in the future in a superlative manner, it *must* be united and stand firm for the principals of individual integrity and not governmental paternalism in the field of medical practice.

To all of you who have participated so willingly and freely, my sincere thanks.

Doctors, you *are* in politics!

Donald E. Hood



LOMOTIL®

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride 2.5 mg.
(Warning: May be habit forming)
atropine sulfate 0.025 mg.

- lowers motility promptly
- relieves spasm promptly
- stops diarrhea promptly

Lomotil fulfills the first order of treatment in most patients with diarrhea — prompt symptomatic control.

Pending discovery of the cause, early cessation of diarrhea is almost always urgently indicated. Prompt symptomatic control averts distress, dehydration and, frequently, severe exhaustion.

Both experimental and clinical evidence indicates that Lomotil exerts such control efficiently, safely and with maximal promptness.

dosage:

The recommended initial *adult* dosage is two tablets (2.5 mg. each) three or four times daily, reduced to meet the requirements of each patient as soon as the diarrhea is controlled. Maintenance dosage may be as low as two tablets daily. *Children's* daily dosage (in divided doses) varies from 3 mg. for a child of 3 to 6 months, to 10 mg. for one 8 to 12 years of age.

cautions and side effects:

Lomotil is an exempt narcotic; its abuse liability is low and comparable to that of codeine. Recommended dosages should not be exceeded. Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates.

Lomotil is a brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of atropine is added to discourage deliberate overdosage.

SEARLE

Research in the Service of Medicine

The Woman's Auxiliary

REPORTS TO ISMA

The executive committee has met at the ISMA Building to perform necessary business at the state level.

The Program Book has been printed, courtesy of Blue Shield. It was compiled by the program chairman, Mrs. A. Alan Fischer, Indianapolis, along with state officers and chairmen, and is being used as a guide for all workers within our 60 auxiliaries.



County auxiliaries are planning programs for the months ahead. Several have set a date for the state president or state officers to visit; namely, the Lake, Henry, Grant, Vigo, Howard, Wayne-Union, Floyd, Clark and Wells County auxiliaries.

State officers and chairmen held very successful Area Workshops in Wabash, Indianapolis and French Lick in September.

The fall issue of *The Hoosier Doctor's Wife* is taking shape in the hands of Mrs. William R. Tindall, Shelbyville, in the absence of our editor, Mrs. Frank Green, Rushville, who is enjoying a well-earned vacation.

The auxiliary president attended the convention of the Kentucky State Medical Association in Louisville, September 28-29.

Our AMA-ERF chairman, Mrs. Donald R. Taylor, Muncie, attended the AMA-ERF Workshop Conference in Chicago, October 1-2.

Indiana was represented at the 21st annual conference, Drake Hotel, Chicago, October 4-7. At this conference national officers, directors and chairmen presented the auxiliary program to presidents and presidents-elect from the 50 states, and ideas were exchanged.

As individual citizens, we must let others know our stand on the issues before November 3! Many are using car "stickers" revealing the presidential and congressional candidates of choice. Think of the votes that could be influenced!

Bea Shields



cough reflex.

Novahistine-DH does not impair ciliary activity or prevent the secretion of normal protective mucus which guards against secondary infection. It should not stimulate pulse rate or cause cerebral excitement. Novahistine-DH is well suited for patients of all ages, especially children, who find its fresh grape flavor particularly agreeable.

Novahistine-DH should be used with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Ambulatory patients should be advised that Novahistine-DH may cause drowsiness.

Sample available to physicians on request. Exempt narcotic — registry number required.

Each 5 ml. teaspoonful contains phenylephrine hydrochloride 10 mg., chlorpheniramine maleate 2 mg., codeine phosphate 10 mg. (Warning: may be habit forming), chloroform (approx.) 13.5 mg., and l-menthol 1 mg. (Alcohol 5%).

Novahistine®-DH

PITMAN-MOORE, Division of The Dow Chemical Company, Indianapolis, Indiana. DOW



Interpreted by
ROBERT HOLLOWELL, LL.B., legal counsel
Indianapolis

Q. How long should a patients' medical records be kept after the death of the attending physician?

A. I know of no way that a definite length of time can be fixed which will apply to all situations. I can only give you certain guideposts for application.

Preservation of the medical records of a deceased physician's patients has a two-fold purpose. One is for the protection of the physician. From this standpoint, they should be preserved for the period of time within which a malpractice case could be brought. As to an adult patient, this is usually two years. As to minors, we are of the opinion that it is also two years, but there is some opinion that a minor can sue until he becomes of legal age.

From the standpoint of service to the patients, it is proper and even desirable that where the patient has a new regular or family physician, for such records to be turned over to the succeeding physician with, of course, the consent of the patient. Where this cannot be done, they should be preserved for a reasonable period of time. What is a reasonable period of time depends upon many factors, including the type of practice the physician had. It is something we can only generalize about.

Not infrequently, patients may have some reason or need for a statement or certificate from the physician relative to his past medical care or treatment. That is why we feel that there is at least a strong moral obligation to the patient to preserve such records as cannot be turned over to a succeeding physician. Another answer is to turn such medical records over to the patients themselves, so that they will have them available to any succeeding doctor who might have occasion to need them.

We always recommend that all medical records of a deceased physician be preserved a minimum of two years from his death. If there is an estate of the deceased physician, then such records shall be preserved until the estate has been finally closed, even though this may exceed two years. In this case, I point out that these records are the property of the deceased physician and his estate may have an interest therein and is entitled to be consulted relative to their disposition.

There is also occasionally a question relating to financial records and records of account. These records are definitely records in which the estate and personal representative of his estate have an interest. Accounts receivable are the property of his estate. Accounts payable are obligations of his estate. These records should either be turned over to the personal representative (executor or administrator) or, in any event, should be preserved until his estate is finally closed and settled. ◄

Type E Botulism Antitoxin

The Public Health Service is stockpiling antitoxin to be reserved for use against type E botulism. It will be stored at PHS Communicable Disease Center, Atlanta, Georgia, which will be on 24-hour call for emergency use.

The CDC emergency number is Area Code 404, telephone 634-2561.

(One of a series of ads being used in key Hoosier newspapers)

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Operation Airlift

APPROXIMATELY 350 Army Reserve officers, nurses and enlisted men and women in the Indianapolis area annually pack up their hospital and fly it west for two weeks of intensive training.

Personnel of the 337th General Hospital (USAR), based at Ft. Harrison, underwent their training at Fitzsimmons General Hospital in Denver this year.

The staff includes everything from cooks and bakers to medical specialists. The medical department officers of the 337th are qualified to practice in virtually every phase of medicine. The list includes general surgeons, oral surgeons, orthopedic surgeons, internists, roentgenologists, anesthesiologists, psychiatrists, psychologists, social service workers, occupational therapists, dentists, optometrists, nurses, pharmacists, physical therapists and general practitioners.

The unit's enlisted personnel are also highly trained to perform other vital functions of a medical or closely related nature. These include laboratory technicians, dental assistants, x-ray technicians, etc.

Dr. Harry Becker, Indianapolis general surgeon, is a colonel and commanding officer of the hospital. Two giant transports and a commercial airline flight took the majority of the personnel and equipment while 25% of the hospital staff traveled by private conveyance.

The unit is completely self-contained and can take charge of a 1,000-bed hospital anywhere in the world, Dr. Becker said, which is what it would do if it were put on a war basis. The medical staff has 30 physicians, 12 dentists, its own food service, supply group and internal security force.

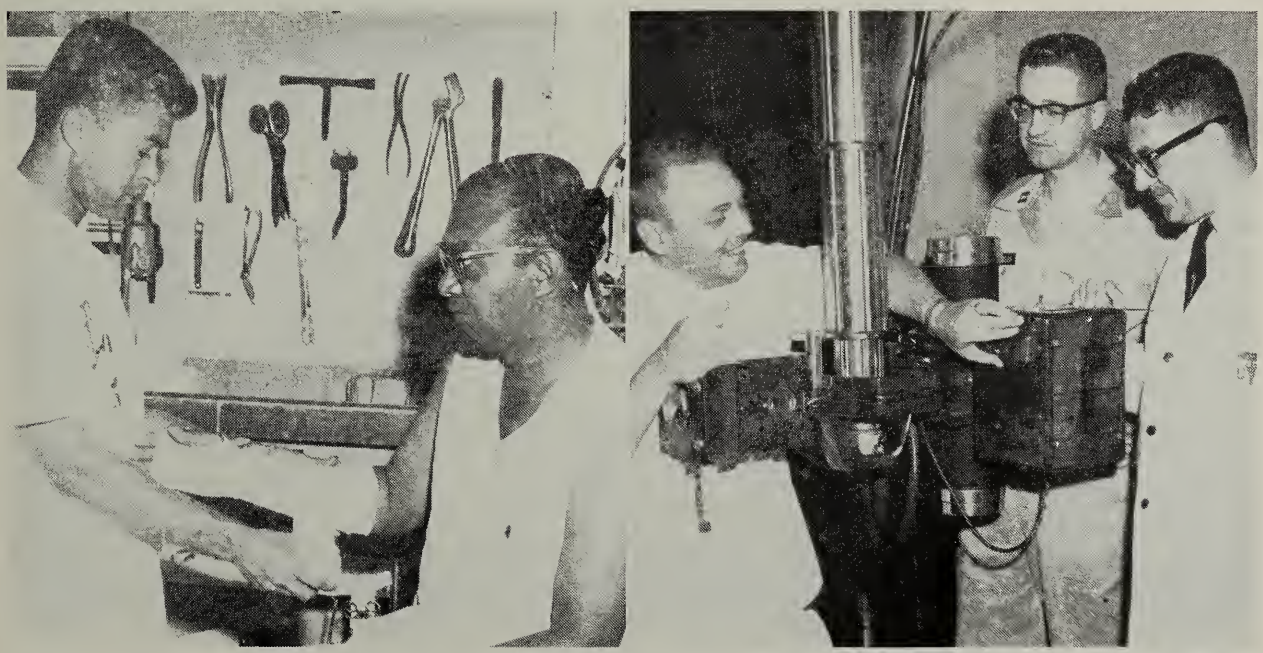
The 337th will take another trip next summer during the month of June. Tentative plans now call for it to be based at Ft. Knox, Kentucky.



FIVE MEMBERS of the 337th get ready for departure from Weir Cook Airport. Shown (left to right) are Capt. William Lockwood, Jr., DC; 1st Lt. Donald Bowers, DC; Capt. George Wessar, DC; 2nd Lt. Gordon Kelly, DC and 2nd Lt. Eugene Day, MSC.



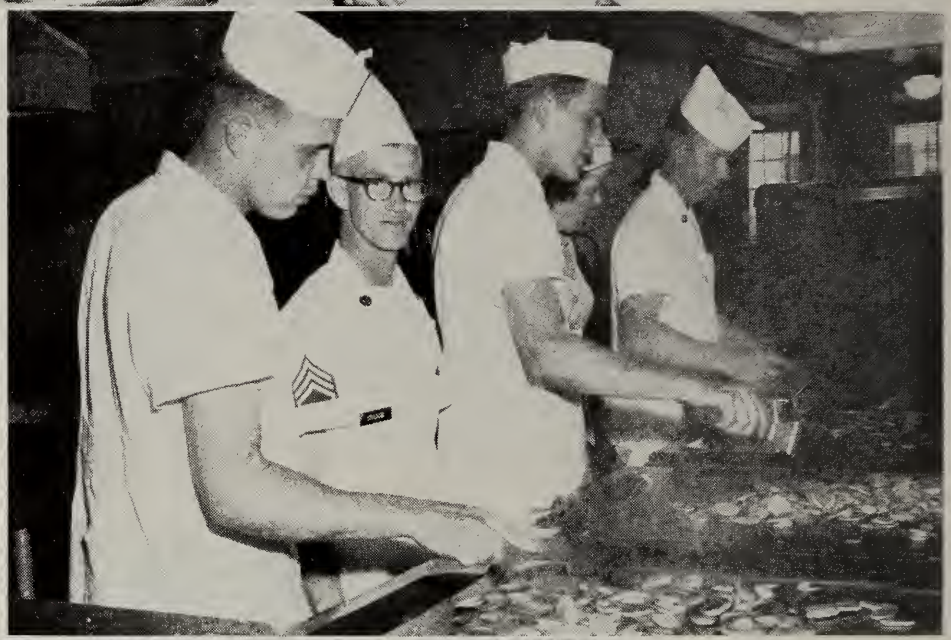
DR. HARRY BECKER, Commanding officer of the 337th General Hospital, oversees the loading of the hospital staff at Weir Cook Municipal Airport.



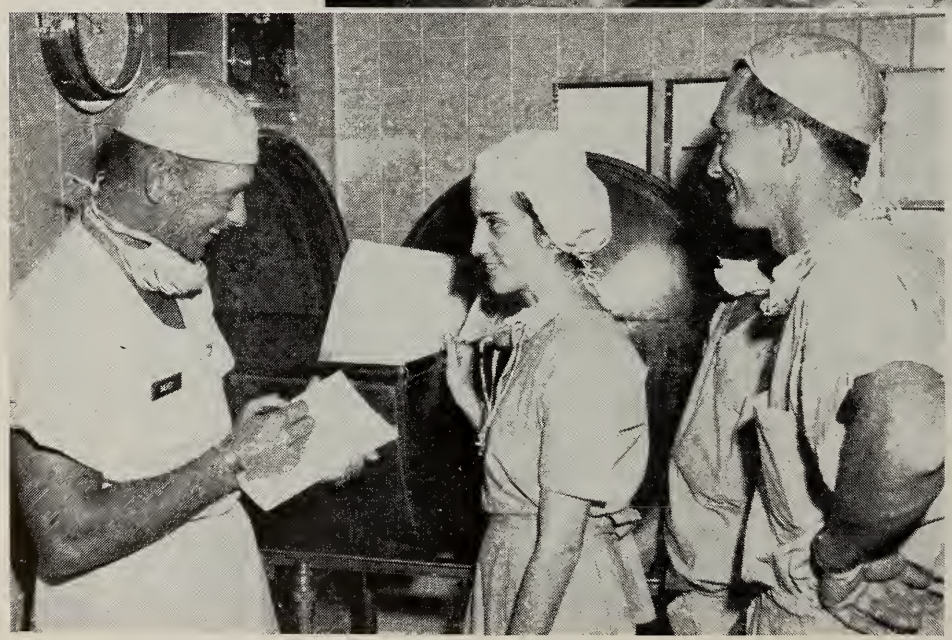
SP-4 RONALD L. HORRALL prepares a patient before applying a cast to his broken arm (left photo). SP-4 James E. Banlore and Capt. Edward C. Wheeler listen to Major Erich K. Lang explain the operation of an x-ray unit (right photo).



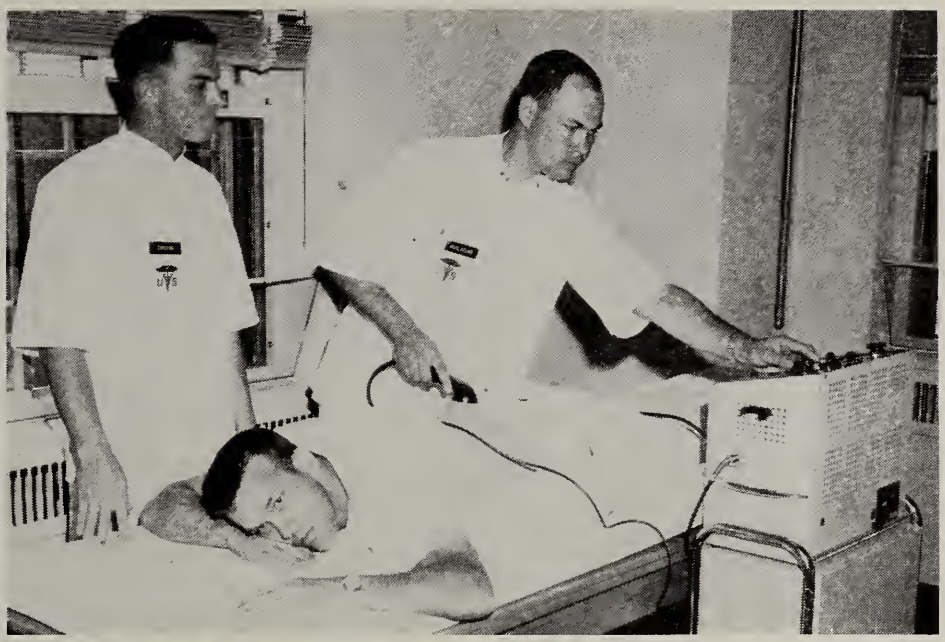
SURGEONS FROM THE 337th medical staff go over the day's surgical schedule. Shown (left to right) are Col. James A. Kirtley, 1st Lt. John A. Bizal, Col. Harry G. Becker, Capt. Kenneth R. Tyson and Col. Lewis G. Morrison.



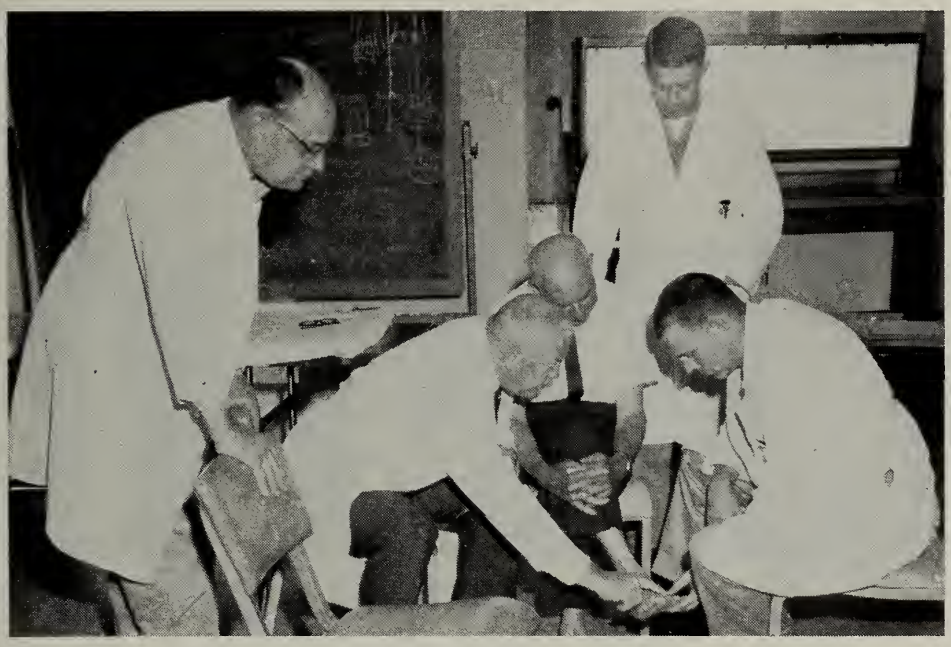
SINCE THE 337th is a completely self-contained unit, there must be cooks, bakers and kitchen help to provide food for the Army Reserve members.



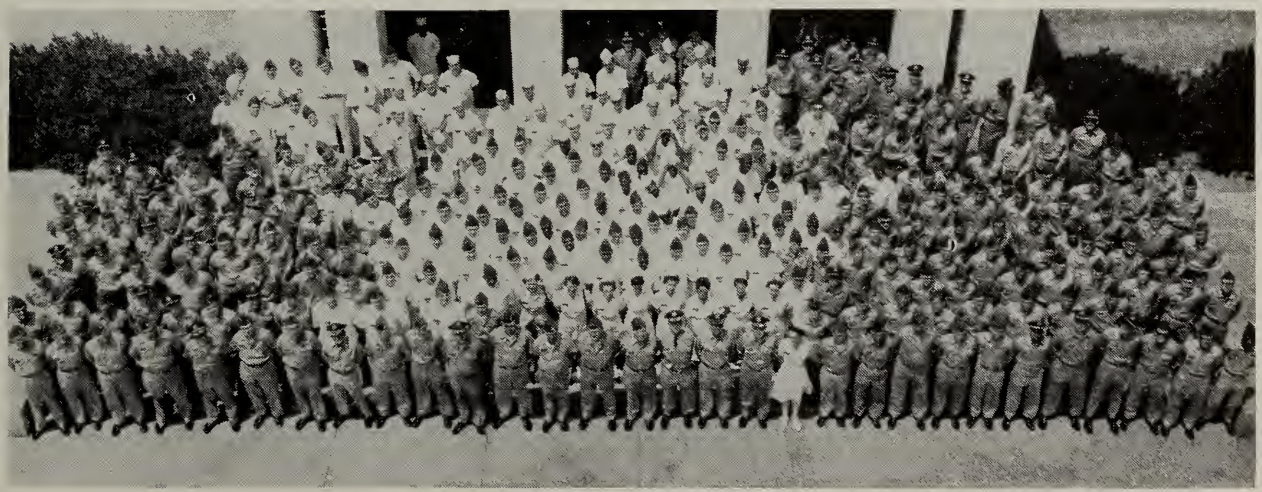
SP-6 JAMES E. SILVEY discusses the sterilization of surgical instruments with Capt. Joyce L. Springmier, SP-5 Bob R. Bond (partially hidden) and SP-4 George N. Wiseman.



ULTRASONIC TREATMENT for an injured back is applied to Capt. John L. Reichard by Pfc. Louis G. Firsich and Capt. James M. McClatchie.



PHYSICIANS watch as a Denver orthopedic surgeon, Dr. Foster Matchett, diagnoses a foot ailment. The physicians are (left to right) Col. Lowell I. Thomas, Dr. Matchett, Capt. Charles H. Warneke and 1st Lt. Lloyd W. Lempke.



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utions: Overgrowth of nonsusceptible organisms may oc- n such cases, discontinue medication and institute appro- specific therapy as indicated by susceptibility testing. inum hydroxide gel given with antibiotics has been shown crease their absorption and is contraindicated.

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DAY BY DAY WITH THE F D A

From the FDA Reports on Enforcement and Compliance.

A New York laboratory was found guilty and fined for shipping, in interstate commerce, foods and drugs produced in unsanitary conditions sufficient to account for contamination with dangerous amounts of diethylstilbestrol. The products concerned were soda mint tablets, antihistamine tablets, dicalcium phosphate tablets and isonicotinic hydrazide tablets. All the contaminated products have been removed from the market. The same laboratory was, in another court action, prevented from selling a chemical, phenylpropanolamine, as an appetite depressant when the drug in the dosage recommended was found to have no value as a weight-reducing agent.

* * *

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The newest cancer "cure" has been removed from interstate commerce. The stuff was called "Mucorhicin" and was claimed to dissolve tumors in a dosage of 15 drops three times a day. If the patient was not afflicted with tumors of any kind, it was recommended as a general tonic. It was made by incubating wheat, salt, yeast and water for 11 days, straining off the liquid portion, and allowing the result to age. The inventors got as much as ten dollars per half ounce, a one-week supply.

* * *

Counterfeit drugs apparently make more money then counterfeit money. Seizures of counterfeit Dexamyl Spansules were made in four states when analysis showed that one drug had been substituted for another. In other seizures, large quantities of unlabeled and mislabeled drugs were involved. "Preparation H Special Laxative," manufactured in Indiana, has been seized because of false and misleading claims.

* * *

Voluntary compliance was brightened by an Indiana manufacturer who destroyed outdated stock of two products and recalled a third when it was found that the suspension formulation was not satisfactory. And an Indiana company spent $45,000 for a new machine and a professional exterminator to enable it to shell and clean popcorn and effectively eliminate a rodent problem.

* * *

The FDA assisted the post office department in the successful prosecution in Shelbyville, Indiana of Roy DeWelles, the "bum gut flusher," who got super-fancy prices for treatments with a device called "Detoxacolon," which proved to be a pressurized enema machine. DeWelles admitted selling over 200 Detoxacolons for $2,500 each. ◄



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Complete literature available on request from Professional Services Dept. PML.

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Coroner System vs. Medical Examiner System: A Medicolegal Issue

*WEI-PING LOH, M.D.**
Gary

THE CORONER SYSTEM is ten centuries old and still exists in many states. The original coroner's office was sired in the tenth century by the need for a method to collect and protect the crown revenue. The original scope of duties of the coroner was broad—he was the principal conservator of peace, the assayer of all weights and measures, the keeper of pleas of the crown and was to investigate felonies, suicides and "ancient treasure" found anywhere on the earth.

He was to assemble a jury, view the body, determine felony, investigate all circumstances of the case and enter the forfeited property of murderers, felons or suicides into the crown revenue. The coroner and the sheriff were both prominent peace officers in those days. For this reason, the local law often states that the coroner is the only county officer who has the power to arrest the sheriff and he is the one to take over the sheriff's office if it becomes vacant.

With the passage of centuries, the sheriff took over many functions of the coroner until finally the coroner's duties were largely confined to the determination of the cause and manner of death under certain circumstances. The coroner's jury and the inquest were retained and the procedure incorporated both legal and medical determinations which were evidently too much to be handled by one person who rarely had qualifications in both fields.

The coroner system has gradually decayed. The coroner today is a county official elected by popular vote and is usually not required by statute to be either a physician or a lawyer. His main qualification is eligibility for a place on the ticket of the predominating political party. He maintains an office and appoints a number of deputy coroners to serve on a salary basis. Both the coroner and his deputies have other professional activities. They all authorize autopsies to be performed by the local pathologists on a fixed fee basis.

Some of the coroners and deputy coroners are poorly qualified or poorly informed as regards their duties, so often they do not visit the scene, view the body or inquire into the circumstances under which the victim died. Because of deficient background and lack of knowledge concerning the death, they often depend on the pathologist to determine the cause of death. In the case of court sessions, the pathologists, not the deputy coroners, are the ones to testify. The inefficiency is often amplified by the fact that the coroner does not have the jurisdiction in many deaths which are of public health or industrial significance.

The Medical Examiner System

The medical examiner system originated in Europe between the 13th and 16th centuries. It was later introduced in the United States and Massachusetts became the first state to adopt such a system, around 1877. The current medical examiner system has the following features:

1. Medical determinations and legal determinations are separate so that each field can be handled with greater efficiency by experts best qualified in their own field. In case of a suspicious homicidal death, the medical examiner is the one who determines whether or not a homicide has been committed. Whether the homicide be justifiable is a legal question and is handled by a legal expert.
2. The chief medical examiner is a skilled pathologist (a doctor of medicine) who is qualified and experienced in legal medicine. He is ap-

* Chief Pathologist, Methodist Hospital of Gary; Assistant Professor of Pathology, Chicago Medical School.

pointed by the governor or the state health commissioner and is less likely to be involved in political issues. He devotes his full time service to upgrading the standards of medicolegal examinations.

3. The chief medical examiner appoints a number of medical examiners (physicians) to serve in their local areas, and is responsible for advancing their knowledge and experience in the medicolegal field. The medical examiner is required to proceed to the scene of any suspicious death and make inquiry into the circumstances.
4. The chief medical examiner maintains complete morgue and laboratory facilities in addition to a central office. He performs medicolegal autopsies by himself and takes charge of all toxicological studies conducted in his laboratory, which is staffed by experts and has the most modern scientific equipment. Unnecessary delay and lack of continuity can thus be reduced or eliminated.
5. The medical examiner has command of local law-enforcing agencies in order to expedite and facilitate his investigation.
6. It has been shown in every area where the medical examiner system has replaced the coroner system that the operating cost is less than the outdated coroner system.

Comment

We all know that the medical examiner system offers much more than the coroner system and has proven its greater value to the community. Why do we still stick to the coroner system which is becoming obsolete? This year is an election year. Let's all make a little noise and strive for a better system. ◄

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Medical Panorama

The FMA—And Others—Perhaps Us

A. W. CAVINS, M.D.
Terre Haute

The July, 1964 issue of *The Journal of the Florida Medical Association* contains comments, from several points of view, upon the 19th annual meeting of the FMA. One of the most interesting, and penetrating, of these is by Millard B. White, M.D., of Sarasota.

After preliminary comment on "the physician who still considers the practice of medicine a private affair between himself and his patient," and a query as to whether "physicians of this persuasion can survive in our present social order," he gets into his main thesis and proposals for improving the situation. Space here does not permit a full reprint, but the following excerpt contains the heart of the matter and might well be pondered upon by Hoosiers as well as Floridians:

> "It is erroneous to assume that the federal government is always the chief villain in creating the new medical environment. The interposition of the economic third party between the physician and his patient was not introduced by government but by industry. Management sees the cost of medical care as a significant budgetary item; labor—a fringe benefit; and, the politician—a free government service to be used to buy votes. All these agencies find it desirable to have a standard fee and a standard service. This, of course, cannot be accomplished without regulation of the physician.
>
> "Statistically, the percentage of the medical care dollar received by the physician for his services is rapidly diminishing. The expanding army of paramedical professions and the gigantic expansion of hospital facilities with its army of lay and medical administrators are challenging the practicing physician's role as the captain of the medical team. There are many other agencies and factors in our American economy that tend to subvert the physician's rightful role in society and threaten the quality of medical care.
>
> * * *
>
> "If the FMA [Florida Medical Association] is to become effective and vital, it should undertake some severe reorganization. First, the business must be put in the hands of able executives. These may, but probably will not be physicians. The physicians must be limited to (a) electing a board of directors to employ executives, (b) setting the policies under which they will operate, and (c) providing the mechanics to enforce these policies. Second, the association must be given adequate financial resources with which to operate. This means a substantial increase, in dues. Each doctor must know that he has some voice in setting policy but that once it is set, he must support it unconditionally.
>
> "Where does an active, practicing physician find the time really to operate organizationally and politically? Does anyone expect the officials of the Teamsters Union to carry on union affairs after they have come in from a long hard day on the highway with a multi-ton truck?
>
> "Nothing in the very narrow training of today's physicians has qualified them in management, politics, economics, administration, or government, yet it is a rare doctor who does not express the feeling that he is an expert in all these fields. A ludicrous sight, if one wishes support of this view, is the business session of any medical group wallowing through routine business matters. With courage matched only by their ignorance, they wade into legal, public relations and other highly technical matters with all the self-confidence that is carefully acquired and displayed in the consultation room and over the hospital bed."
>
> * * *
>
> "The association carries on this charade of democracy, suffering from all its ills, but profits from none of the strength of this system. It attempts to do so with little money and in the spare time which its officers find after they have completed their busy day's practice. Its officers try to do these things well, and in competition with experts, without training or experience in these various fields. Why would

Continued



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Continued

not anyone who really believes in medicine's cause be discouraged and overwhelmed with a sense of futility?

"The FMA convention can be more effective as an instrument to further the educational and organizational needs of the physician. Education in the science of medicine is well served by the specialty meetings. General scientific sessions should be eliminated and replaced by workshops in the fields of economics, public relations and the mechanics of politics given by experts in these fields for the purpose of making the individual physician effective through political action at the "grass root" or patient-physician level. An interim meeting of the House of Delegates in various parts of the state would permit more physicians to participate in the affairs of the association.

"Will the physicians of Florida ever become a part of an effective organization to meet the challenge of our new environment? Or—will we continue to look after our individual interests, express our uninformed extemporaneous opinions freely, exercise every possible 'freedom from' and try to make the best individual deal we can with those who are rapidly acquiring control over us?"

One of the most difficult feats in the realm of human nature and affairs is to stand off to one side and have a really good look at one's self. Dr. White has attempted to do this and he may have done it better than some others who have tried to do the same thing. Regardless of one's feeling in the matter there is certainly food for thought here, and if such a diet for cerebration causes some of our members to become articulate and/or otherwise active, so much the better. ◄

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Medicine At Law

DECISIONS AND OPINIONS

Highlights of recent court actions pertaining to health and medicine from *The Citation* prepared by the Law Division of AMA.

Evidence Raises Jury Question of Doctor's Negligence in Treating Fracture—In an action by a patient against a doctor for damages for his alleged negligence in setting the patient's elbow fracture in a closed reduction, there was evidence from which a jury could find that the doctor was negligent in failing to refer the patient to an orthopedic specialist and that this was the proximate cause of the patient's injury, the Michigan Supreme Court ruled. A directed verdict in favor of the doctor was reversed and the case remanded for a new trial.

The doctor, a general practitioner, set the comminuted fracture of the four-year-old patient's left elbow in a closed reduction. There was also damage to the epiphysis of the elbow. When the patient continued to have troubled with the arm, an orthopedic surgeon performed several corrective operations.

The patient contended that the doctor's failure to refer him to an orthopedic specialist was negligent and caused painful and permanent injuries to his arm. A general practitioner who testified for the patient stated that the doctor violated the standard of practice in the same or similar localities by failing to refer the patient to an orthopedic specialist who, in his opinion, would have discovered the damage to the epiphysis of the elbow at the outset. The orthopedic specialist who performed the corrective surgery testified that he could see the epiphyseal injury on the original x-rays taken by the doctor. A jury could have found from this evidence that the doctor was negligent in failing to refer the patient to an orthopedic specialist, the court ruled.

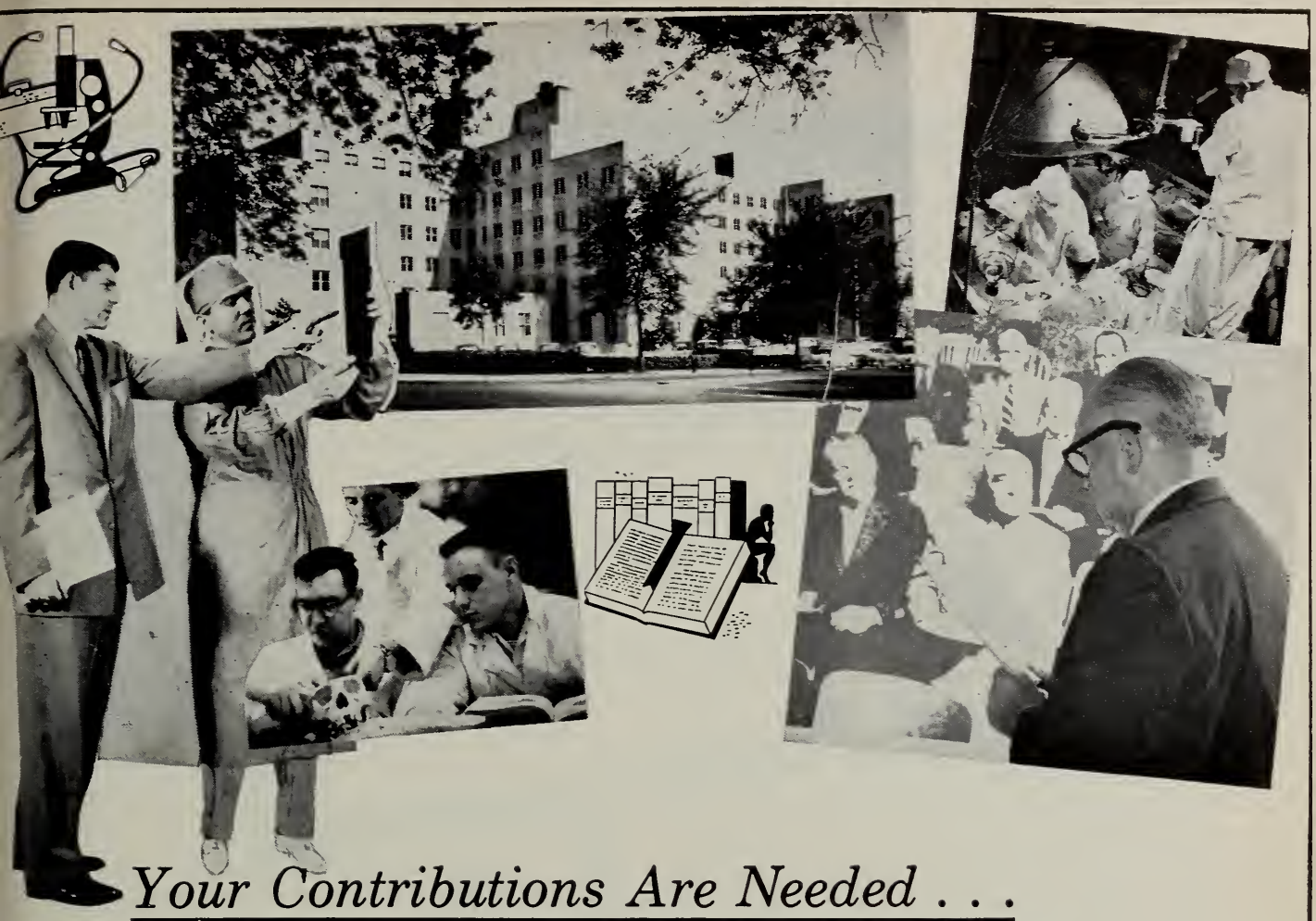
The general practitioner who testified for the patient stated that an orthopedic specialist would have discovered the epiphyseal damage immediately and would have set the fracture by open reduction and the insertion of noncorrosive pins. This was evidence from which a jury could find that, if the patient had been referred to an orthopedic specialist immediately, his arm would not have been permanently and painfully injured, the court ruled.

Morgan v. Engles, 127 N.W. 2d 382 (Mich., Apr. 6, 1964).

Federal Trade Commission's Request for Injunction to Restrain Analgesic Manufacturer's Ads Denied—The Federal Trade Commission was not entitled to an injunction ordering the manufacturer of an analgesic product to refrain from disseminating certain advertisements, based on the results, as published in *The Journal of the American Medical Association,* of a study of five analgesic products, which study had been made under a grant from the FTC, where the evidence failed to support the FTC's allegation that the statements in the advertisements were significantly false and misleading, a federal trial court ruled.

There is intense competition among manufacturers and distributors of various types of analgesic drugs, such as Bayer Aspirin, St. Joseph's Aspirin, Anacin, Bufferin, and Excedrin, and, in 1961, administrative complaints were filed by the FTC with respect to the advertising claims of all of those products. No hearings have been held on those complaints, and the FTC, perhaps in preparation for the hearings, authorized and financed a study of the five

Continued



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AMA-ERF

American Medical Association
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535 North Dearborn Street
Chicago 10, Illinois

named products by two doctors and a medical statistician.

After much urging by those who made the study, the FTC permitted them to publish the results in *The Journal of the American Medical Association.* The manufacturer of Bayer Aspirin regarded the results as favorable to its product and began an advertising campaign publicizing the results of the study.

The FTC conceded that there was nothing in the advertisement that was false, *per se.* It argued that the advertisement as a whole created a false impression.

The FTC contended that the advertisement created the impression that the results of the study were endorsed and approved by the United States Government. The advertisement contains no such statement. It refers to a "Government-Supported Medical Team," which is a true statement. If any false impressions were created as to the origin of the study, they were created by the FTC's own actions in picking the team, supporting it with a grant, and authorizing the release of the report of the study, the court said.

The FTC claimed that the advertisement connoted that the results of the study were approved by the American Medical Association. The advertisement does no more than say that the findings were reported in *The Journal of the American Medical Association,* which is true.

The FTC objected specifically to the following part of the advertisement:

> "According to this report, the higher priced combination-of-ingredients products upset the stomach with significantly greater frequency than any of the other products tested, while Bayer Aspirin, taken as directed, is as gentle to the stomach as a plain sugar pill."

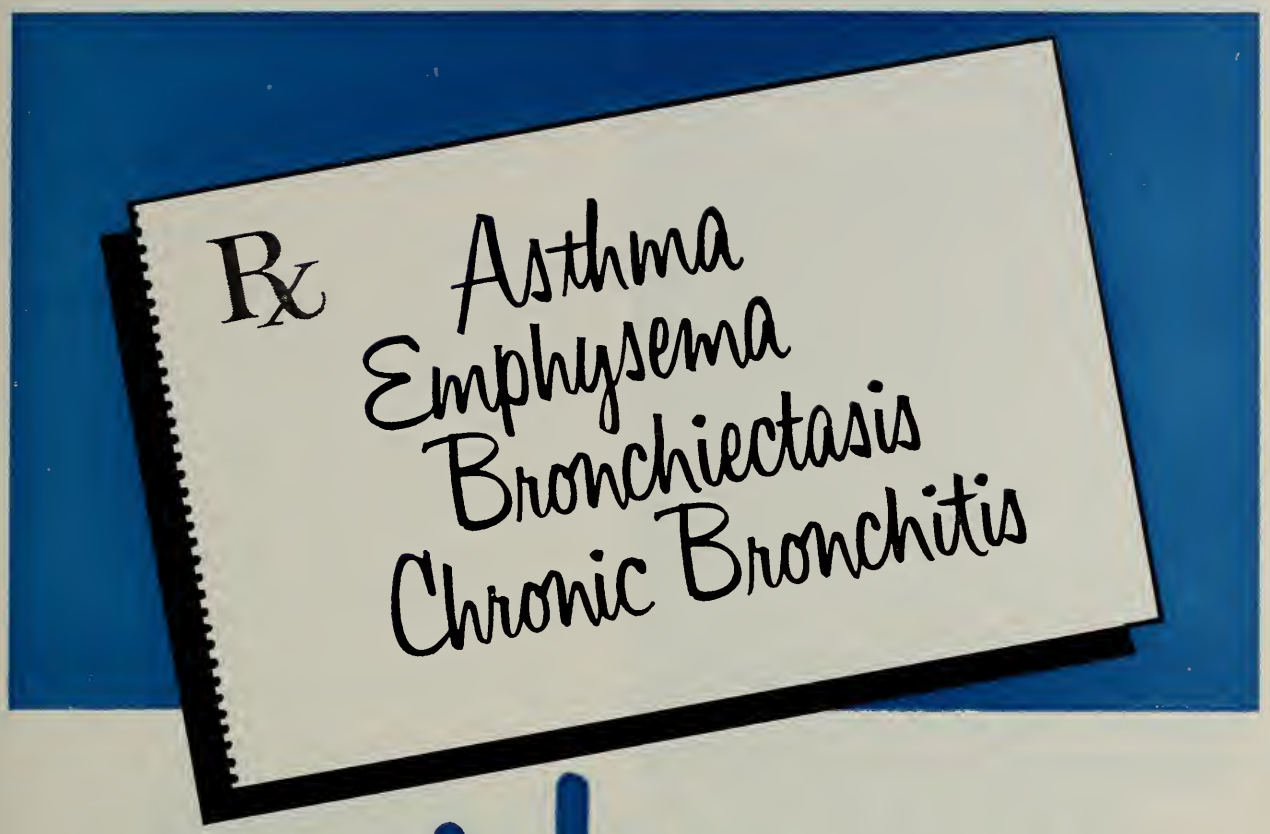
The FTC contended that it was a misrepresentation to use the words "sugar pill" rather than "placebo," which was used in the report. Describing the placebo as a sugar pill was not false and misleading in view of the fact that the placebo was made up of sugar and a binder. The statement was made more understandable to the reader by the use of the words "sugar pill" instead of the technical word "placebo," the court said.

The FTC also argued that the claim as to the difference in gastrointestinal side effects was false. The report stated that the incidence of gastrointestinal side effects was higher after Anacin and Excedrin, two of the combination-of-ingredients products.

The FTC contended that the statement in the advertisement that Bayer Aspirin afforded a higher degree of pain relief than any other product tested at the end of fifteen minutes was misleading. The advertisement stated that "there is no significant difference" with reference to relief and went on to say, "Nonetheless, it is interesting to note that within just fifteen minutes, Bayer Aspirin had a somewhat higher pain relief score than any of the other products." This was exactly what the published report showed, the court said.

If the advertisement had contained the representations that the FTC claimed it contained, an injunction would have been granted, the court said. However, the facts showed that the advertisement did not contain those representations, and the FTC failed to show that it would cause the average, reasonable person to draw the inferences drawn by the FTC from it.

Federal Trade Commission v. Sterling Drug Company, 215 F. Supp. 327 (D.C., N.Y., March 8, 1963). ◄



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The Bronchodilator with the intermediate dose of KI

The fast-disintegrating, uncoated tablet gives relief to the asthmatic in 15 minutes. The ephedrine-phenobarbital balance eliminates nervousness. It relaxes broncho-constriction, liquefies mucus-plugging and is buffered for tolerance.

Each tablet contains Aminophylline 130 mg., Ephedrine HCl 16 mg., Phenobarbital 22 mg. (Warning: may be habit-forming), Potassium Iodide 195 mg. Dosage: One tablet, 3 or 4 times a day. Precautions: Usual for aminophylline-ephedrine-phenobarbital. Iodides may cause nausea, and very long use may cause goiter. Iodide contraindications: tuberculosis, pregnancy. Issued in 100's, 1000's.

Also available as

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Formula is identical to Mudrane except that Glyceryl Guaiacolate 100 mg. replaces the Potassium Iodide as the mucolytic expectorant. Issued in 100's and 1000's.

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The formula of four teaspoonfuls Elixir equals one Mudrane GG tablet. Dosage 6 to 12 years: One to two teaspoonfuls 3 or 4 times a day. Under 6 years, adjust dosage according to age. Issued in pints and half gallons.

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Letter

to the editor

August 21, 1964

To the Editor:

Thanks very much for the copies of *The Journal* featuring our symbol on the cover. It is a beautiful cover. As a matter of fact, I think *The Journal* is just about the best magazine of its kind I've ever seen.

We were so impressed that we'd like very much to obtain copies of the August issue for members of our Medical Advisory Board, and I wonder if it would be possible to get hold of about two dozen or so?

Again, thanks very much.

Sincerely,
Shel Sukoff
Director of
Public Information
The Epilepsy League ◄

66 . . . 99

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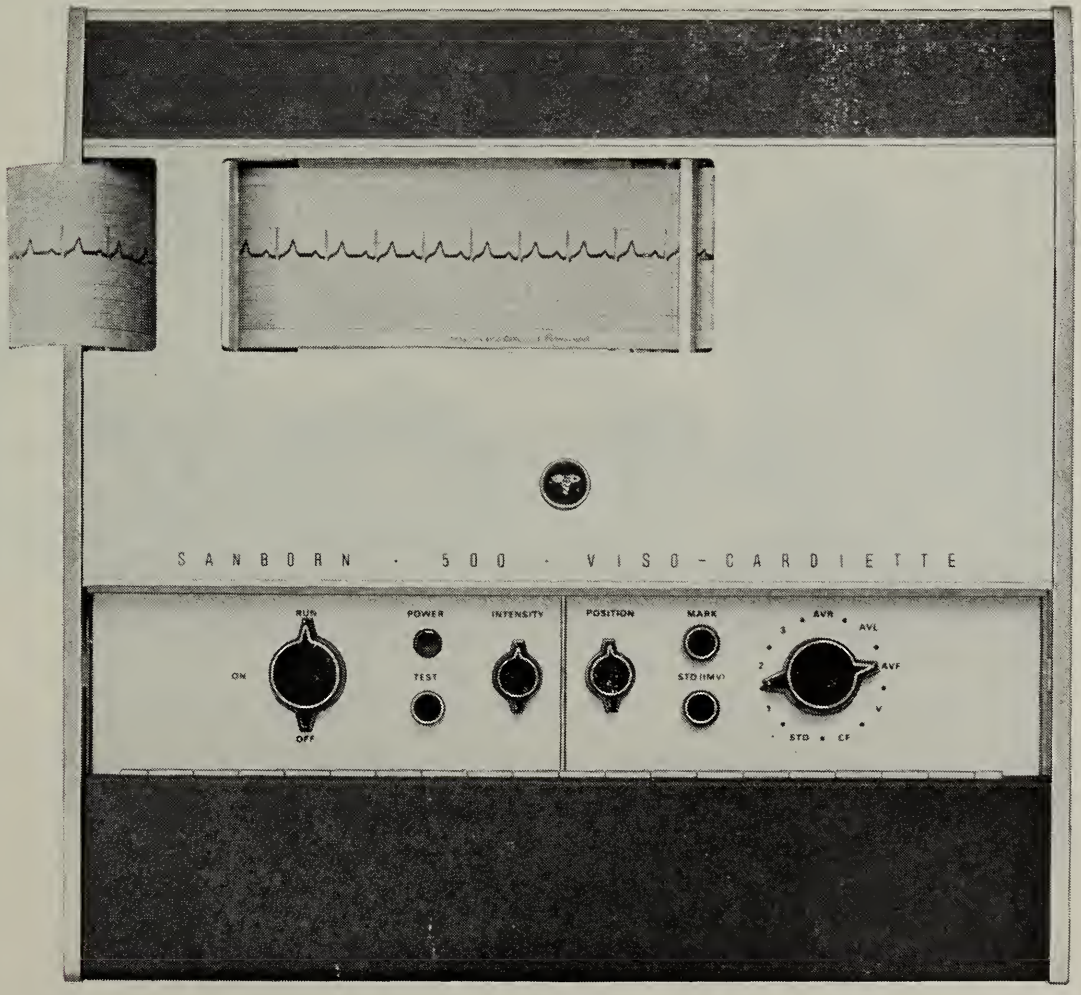


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Model 500 Viso-Cardiette, $695 complete (delivered, continental U.S.); with optional Model 500-1100 Cart, $820. Call your local Sanborn Branch Office now. Sanborn Company, Medical Division, Waltham, Mass. (02154), a Division of Hewlett-Packard.

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ABSTRACTS

BOOK REVIEWS

MARRIAGE COUNSELING IN MEDICAL PRACTICE

A symposium edited by Ethel M. Nash, M.A., Lucie Jessner, M.D., D. Wilfred Abse, M.D., The University of North Carolina Press, Chapel Hill, North Carolina, 1964; 368 pages.

This book is made up of a collection of essays on the broad subject of sex behavior and marital problems. These discussions were given in shorter form at symposia at Greensboro, North Carolina, and Chapel Hill, North Carolina, in 1961 and 1962. The symposia were given particularly for practicing physicians to enable them to better handle marriage problems which arise in private practice.

The contributors in the main are engaged in some division of the field of psychiatry; but chapters by an obstetrician and a pediatrician are included. At the end of the volume there is a useful annotated book and periodical list, and also detailed marital history forms for use by physicians or others engaged in marital counseling.

Many detailed case reports are included in the text, and sexual problems, real or imagined, are discussed in detail. Since physicians have a responsibility to the patient in matters of family life, and sex attitudes and behavior, some knowledge in this area is highly desirable and should be included in the teaching of medical students.

Much of marriage counseling in this country is done by non-professional people who are not qualified by training or experience, and medical graduates are woefully lacking in basic knowledge in this area.

The Bowman Gray School of Medicine has a four-year course in marriage counseling to better equip graduates to adequately handle this aspect of medical care. Anyone who deals with family planning and marriage problems, not only physicians, but ministers and social workers as well, will derive much information from reading this book. The average physicians may consider the text to be somewhat verbose.

DAVID A. BICKEL, M.D.
South Bend

CURRENT THERAPY, 1964

Edited by Howard F. Conn, M.D., with 12 consulting editors and several hundred contributors; 797 pages, numerous tables; W. B. Saunders Company, Philadelphia, $13.00.

The continuing enormous popularity of this best seller testifies to the fact that it fills a very definite niche in the reading habits of the medical profession. The Encyclopedia Britannica publishes an annual yearbook; why not *Current Therapy?*



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The still living (may he enjoy many more years) but already legendary Dr. Morris Fishbein is supposed to carry in his head a fairly complete dossier on just about every doctor of any importance alive today. Dr. Conn is rapidly getting into that category. He certainly has the knack of picking the right man for the right subject.

It is a fact that *Current Therapy* can give one a compact summation of the HOW in the therapy of just about every conceivable disease. No student of medicine—be he still in medical school or an erudite professor—can afford to be without a copy. What more can a reviewer say?

ARNOLD LIEBERMAN, M.D.
New York, N.Y.

Abstracts From Various Literature, Prepared by AMA

VERTICAL VERSUS HORIZONTAL LAPAROTOMIES. I. EARLY POSTOPERATIVE COMPARISONS

N. A. Halasz (1124 W. Carson St., Torrance, Calif.)
Arch. Surg. 88:911 (June), 1964.

One hundred patients undergoing biliary operations were assigned vertical or transverse incisions at random. Twenty percent of the patients with vertical incisions developed significant pulmonary complications, in contrast to only two percent of those with transverse incisions. Analgesic requirements roughly paralleled this pattern. Early wound problems also occurred with equal frequency in both groups, but deep (subfascial) infections were limited to those with vertical incisions. Wound hernias and other late complications will be dealt with in a follow-up study.

INITIAL HEPARIN THERAPY IN ACUTE MYOCARDIAL INFARCTION

K. W. G. Brown (922 Medical Arts Bldg., Toronto) and R. L. MacMillan
Canad. Med. Assoc. J. 90:1345 (June 13), 1964.

The administration of heparin during the first 48 hours after acute myocardial infarction is widely practiced. Heparin treatment is also recommended for acute coronary insufficiency on the grounds that it may prevent development of an impending myocardial infarction. These measures were accepted without support of a controlled clinical trial. By random selection, 101 patients hospitalized with a provisional diagnosis of fresh myocardial infarction received heparin (100 mg intravenously every 8 hours for 48 hours) and 105 patients were assigned to a control group. Both groups of patients received dicumerol. The mortality in the heparin series was 30% and in the control group, 28%. A significantly larger number of the heparin-treated patients developed clinical and laboratory proof of recent myocardial infarction. It is concluded that early intermittent intravenous heparin treatment does not lower the mortality in patients with acute myocardial infarction, nor does it prevent impending myocardial infarction in patients with acute coronary insufficiency.

THE RESPONSE OF STROKE PATIENTS TO VERY SMALL DOSES OF PARENTERAL RESERPINE

S. C. Leonberg, Jr. (Pennsylvania Hosp., Philadelphia), J. B. Green, and F. A. Elliott
Ann. Intern. Med. 60:866 (May), 1964.

Despite the conventional recommendation that reserpine administered parenterally in doses of 2.5 to 10 mg is a safe agent for the treatment of hypertensive crises, the authors observed ten patients who responded remarkably to much smaller doses. All of these patients had suffered recent "strokes." Their responses are tabulated, and three cases are reported in some detail. The relationship of these unusual responses to the central and peripheral actions of reserpine is considered.

VINCRISTINE IN TREATMENT OF NEOPLASTIC DISEASE

D. M. Whitelaw (5760 Marguerite, Vancouver, B.C.) and H. S. Kim
Canad. Med. Assoc. J. 90:1385 (June 20), 1964.

Seventy-eight patients with advanced malignant disease were treated with vincristine, an alkaloid derived from Vinca rosea Linn. Fifty-nine of these survived one month from the beginning of treatment and could be evaluated. Twenty made a good response with return to activity and more than 75% regression of tumor deposits. Seven made a fair response with resumption of partial activity and at least 25% regression of tumor deposits. Favorable results were seen in patients with Hodgkin's disease, reticulum cell sarcoma, lymphosarcoma, carcinoma of the breast, acute leuke-

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Bates and Christie—*RESPIRATORY FUNCTION IN DISEASE*
New!—A valuable aid in managing those patients suffering from lung conditions.

ABSTRACTS

Continued

mia, and choriocarcinoma. The duration of remission is usually brief but in five instances it exceeded six months. Toxic reactions include a high incidence of alopecia and neurological complications. The bone marrow depression is constant and predictable.

THE CARCINOID CRISIS

M. E. Kahil, H. Brown (Baylor University College of Medicine, Houston), and H. L. Fred

Arch. Intern. Med. 114:26 (July), 1964.

A woman with the carcinoid syndrome in whom a bout of flushing was accompanied by profound hypotension and striking pruritus and hyperesthesias was seen. Levarterenol accentuated her symptoms and failed to produce a pressor response. Subsequently, the intravenous administration of an antiserotonin compound (cyproheptadine) was followed by immediate subjective relief as well as by a return of the blood pressure to normal levels. The occurrence of peripheral vascular collapse as an occasional manifestation of the malignant carcinoid syndrome is emphasized, and its management is briefly discussed.

MASSIVE HEPATIC NECROSIS ASSOCIATED WITH HALOTHANE ANESTHESIA

D. A. Chadwick, R. C. Jennings (General Hosp., Altrincham, Cheshire, England)

Lancet 1:793 (April 11), 1964.

A fatal case of postoperative massive hepatic necrosis is described. The patient had been anesthetized three times with halothane during the three weeks prior to the onset of jaundice. No other hepatotoxic agents had been administered.

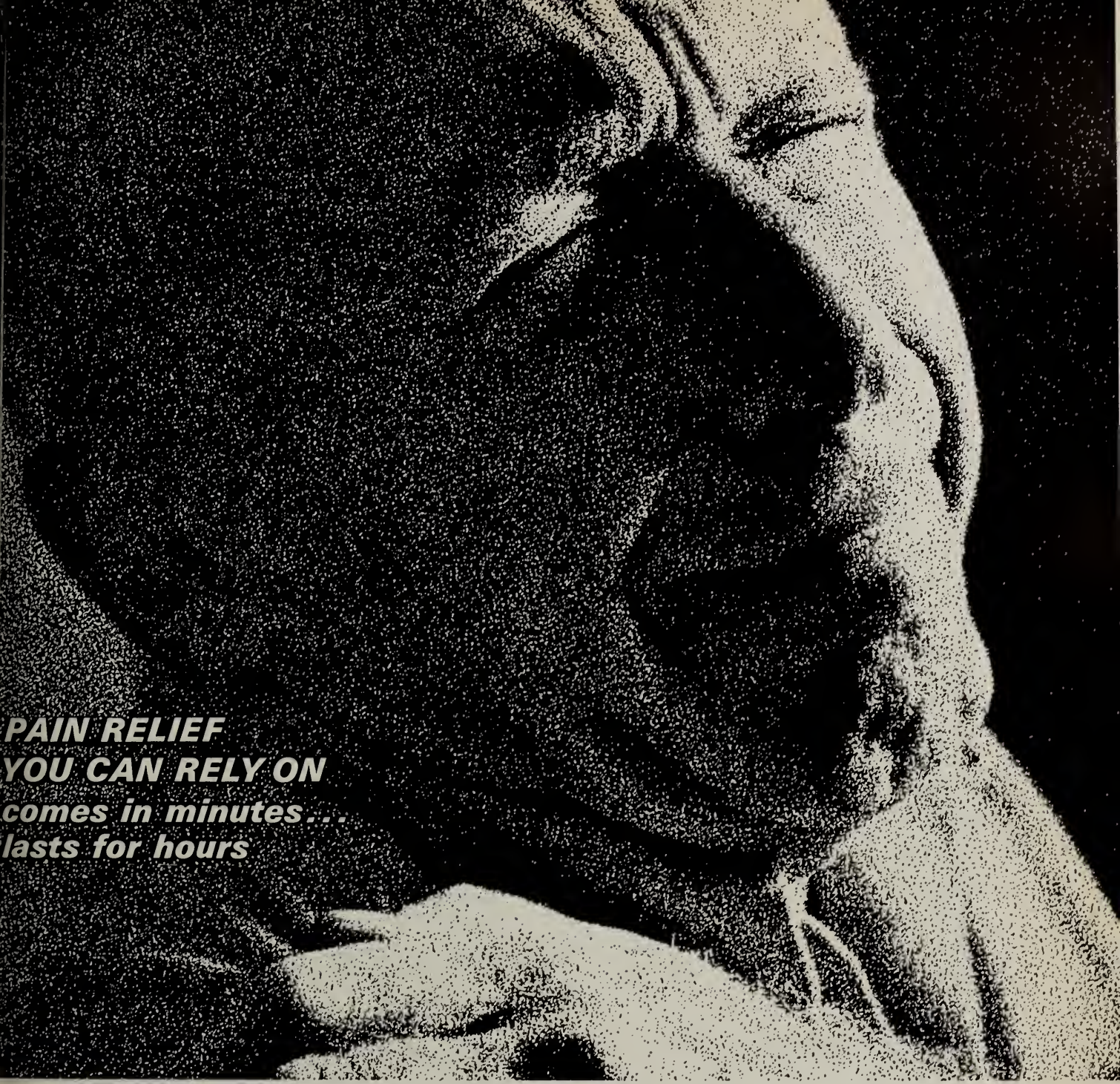
IRON IN ALCOHOLIC BEVERAGES. POSSIBLE SIGNIFICANCE FOR HEMOCHROMATOSIS

R. A. MacDonald (784 Massachusetts Ave., Boston) and N. Baumslag.

Amer. J. Med. Sci. 247:649 (June), 1964.

The iron content of 98 commercial and illicit alcoholic beverages in Johannesburg, South Africa, was measured. Beer, brandy, and gin contained less than 1.0 mg iron per liter. Wine contained as much as 6.9 mg per liter. One hundred white male chronic alcoholics were questioned about alcohol consumption. Twenty percent stated that wine was their customary alcoholic beverage; an average of three and one-half quarts was consumed per day. By calculation, wine consumption could result in the ingestion of 10.8 to 26.6 gm over a 20-year period, comparable to the amounts found in the tissues in hemochromatosis. When patients with hemochromatosis or hemosiderosis are encountered, a search should be made for possible sources of excess dietary iron. ◄





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This year marks the 25th anniversary of the founding of the first Blue Shield type plan.

The fledging California Medical Association infant of 1939 was the first step in a phenomenal quarter century of growth. Starting with this plan, followed later in 1939 by a Blue Shield plan in Michigan, Blue Shield has grown to where it now comprises a network of 83 independent plans in the United States, Canada, and Jamaica coordinated by the National Association of Blue Shield Plans in Chicago.

From barely 12 million subscribers in 1949, 10 years after its inception, membership in the succeeding 15 years has soared to over 53 million. Benefits paid to a record 53,450,349 Blue Shield subscribers in 1963 topped the billion dollar mark for the first time.

Created by the Indiana State Medical Association in 1946, Indiana Blue Shield has grown at a rate equal to that of Blue Shield plans nationally. Present membership is above the 1,500,000 mark, almost one third of the state's population, and since organization, Indiana Blue Shield has paid members more than $165,000,000 for doctors' bills.

What are the reasons for such an outstanding growth record?

Coming out of the depression in the late '30's, Americans felt the need for a vehicle which would enable them to prepay their medical expenses. The financial ravages of the depression were disastrous to those who incurred heavy medical expenses. Bills piled up at home and accumulating medical expenses wiped out savings and mortgaged earnings for years to come.

The government was ready with a compulsory health insurance program when Blue Shield and other voluntary health care prepayment plans were made available to the people. Americans, given the opportunity to choose between government and voluntary health care, voted with their dollars for the voluntary approach in overwhelming numbers. Today, more than 77% of the United States population has some form of a voluntary health care prepayment plan.

Blue Shield covers 26.41% of the United States population, handling 46% of the medical and 36% of the surgical coverage in the United States. Nearly 50% of all those with some form of health care prepayment protection in this country have Blue Shield.

The main reason for this widespread acceptance of Blue Shield is that benefits have kept pace with the tempo of the times. Members always receive more benefits for their health care prepayment dollar with Blue Shield than they could anywhere else.

Blue Shield discovered that it could extend benefits that it once thought impossible. Primarily, this was due to the unique relationship that Blue Shield has with both doctor and patient . . . and the nonprofit character of the organization.

At first, many Blue Shield plans limited coverage to in-hospital surgical cases. A few included obstetrical cases and fewer offered limited coverage for non-surgical cases. Some plans paid for surgery outside the hospital and a few made necessary and formal consultations inside the hospital eligible for benefits. Almost all plans excluded coverage for diagnostic services and for home and office visits.

Today, Blue Shield plans generally offer surgery in or out of the hospital, without limitation as to the number of procedures; obstetrical services in or out of the hospital, and medical services in the hospital to 120 days or more.

Also offered generally are general anesthesia services in the hospital by a physician anesthesiologist not employed by the hospital; diagnostic or therapeutic x-rays, and professional laboratory interpretations in or out of the hospital.

Blue Shield, upon attaining the quarter century mark, has not paused to rest on its considerable laurels. It is moving ahead to new horizons of broader coverage for more people. ◄

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Larry W. Goetz, Quarters 8672, Fort Lewis, Wash. 98433

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J. E. Schmidt, 934 Monroe St., Charlestown, Ind. —*Assistant to a physician, industrial or institution practice*

Elmer E. M. Johnson, 9106 117th St., Edmonton, Alberta, Canada—*Insurance medicine*

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Robert W. Steagall, Jr., 1349 Druid Park Ave., Augusta, Ga.—*Dermatology*

Kenneth B. Hatfield, 103 Villa Ave., Buffalo, N. Y. 14216—*Internal Medicine*

Robert D. Collins, 20 Scarsdale Dr., Harrisburg, Pa.—*Internal Medicine*

Gerard A. Weigel, 3566 Strathmoor Dr., Dayton, Ohio—*Internal Medicine and Insurance Medicine*

Gerald Ratinov, 2527 S. Admiral Dr., Forrestal Village, Great Lakes, Ill.—*Neurology*

Duane H. Smith, 395-7 Rimrock Terrace, Fort Riley, Kan.—*Ob-Gyn.*

Donald W. Shanabrook, 2654 E. 114th St., Cleveland, Ohio 44104—*Ob-Gyn.*

David Lee Sarrett, 104 Jackson Ave., Sandston, Va. —*Ob-Gyn.*

Henry I. Glick, 260 N. E. 175 Terrace, Miami, Fla. —*Ob-Gyn.*

Daniel R. Evans, 1100 W. Michigan St., Indianapolis, Ind.—*Ophthalmology*

Costas S. Paissios, 41 Constantinople St., New Smyrna, Athens, Greece—*Orthopedics*

Robert G. Howgland, 6824 Redman, Wayne, Mich. —*Orthopedics and Hand Surgery*

Joseph R. Prokop, 1416 Remington Rd., Philadelphia 51, Pa.—*Pediatrics*

Robert M. Sweeney, 3125 Winfield, Indianapolis, Ind. 46222—*Pediatrics*

William H. Morris, Jr., 24 Crain St., Fort Rucker, Ala. 36362—*Pediatrics*

Alberto Diaz de Leon, Margaritas #8, Matamoros Tamps, Mexico—*General Surgery*

Warren W. Kaebnick, 555 N. E. 128th St., North Miami, Fla.—*General Surgery*

A. K. Moghal, St. Louis Marie de Montfort Hospital, Montreal Road, Ottawa, Ontario—*General Surgery*

Edward H. Cornell, 5 Aspen St., Malmstrom AFB, Great Falls, Mont.—*General Surgery*

Donald P. Davis, 204 Queen St., Beckley, W. Va. —*General Surgery*

Donald P. Feeney, 15 Hillsdale Rd., Trenton, N. J. —*Urology*

R. W. Helmich, 4026 W. Maryland Ave., Phoenix 19, Ariz.—*Urology*

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Annual Meeting Dates of Professional Medical and Allied Organizations

AMERICAN MEDICAL ASSOCIATION CONVENTION
Date June 20-24, 1965
Place New York, N. Y.

AMERICAN COLLEGE OF SURGEONS, INDIANA CHAPTER
Date May, 1965
Place Evansville

BONE AND JOINT CLUB
Date October 14, 1964
Place The Athenaeum, Indianapolis

INDIANA ACADEMY OF GENERAL PRACTICE
Date March 9-11, 1965
Place Murat Temple, Indianapolis

INDIANA STATE SOCIETY OF ANESTHESIOLOGISTS
Date May 15, 1965
Place Indianapolis Athletic Club

INDIANA SOCIETY OF INTERNAL MEDICINE
Date November 22
Place Sheraton-Lincoln Hotel, Indianapolis

INDIANA HOSPITAL ASSOCIATION
Date October 28-29
Place Speedway Motel, Indianapolis

INDIANA NEUROPSYCHIATRIC ASSOCIATION
Date Second Wednesday of every month, October through May
Place The Athenaeum, Indianapolis

INDIANA STATE MEDICAL ASSOCIATION CONVENTION
Date October 12-15
Place Murat Theater, Indianapolis

INDIANA OBSTETRICAL AND GYNECOLOGICAL SOCIETY
Date November 4
Place Marott Hotel, Indianapolis

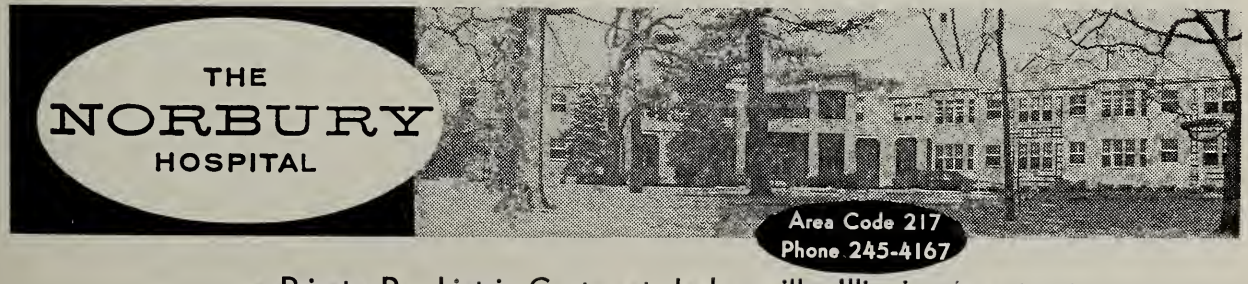
INDIANA ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY
Date May 7-8, 1965
Place Oakbrook, Ill.

INDIANA ORTHOPAEDIC SOCIETY
Date May, 1965
Place Indianapolis

INDIANA CHAPTER of the AMERICAN ACADEMY OF PEDIATRICS
Date April 21-22, 1965
Place Marott Hotel, Indianapolis

INDIANA ROENTGEN SOCIETY
Date May, 1965
Place Indianapolis

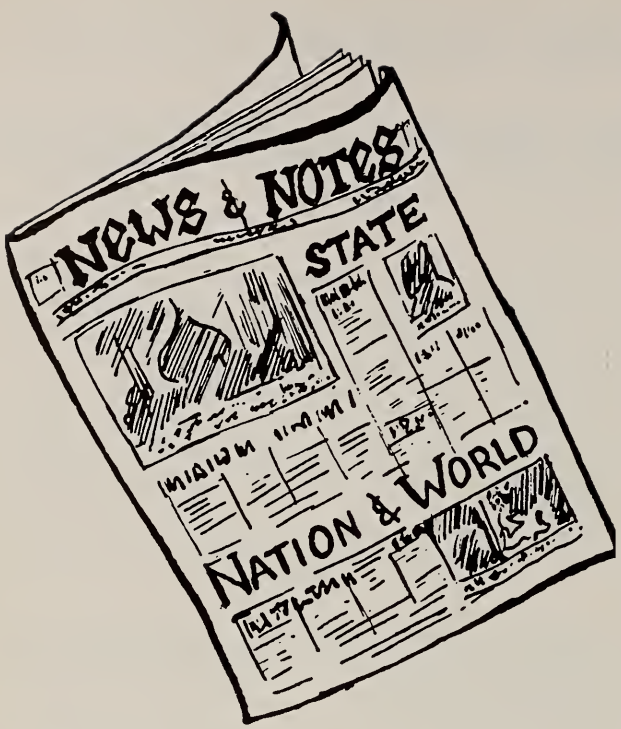
NORTHERN INDIANA PSYCHIATRIC SOCIETY
Date Fourth Wednesday of every month, September through June
Place For location and program, inquire Beatty Memorial Hospital, Westville



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Complete psychiatric treatment in an environment for cure. A 50 bed hospital with the most modern diagnostic and therapeutic equipment for the treatment of nervous and mental disorders.

LICENSED: Illinois Department of Mental Health.
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American Physicians and Surgeons Association Sets Essay Contest

The Association of American Physicians and Surgeons announces the 19th Annual Essay Contest for High School Students to be sponsored in cooperation with various state and county medical societies. A $1,000 first prize will be awarded in the national finals together with many other cash prizes and honorable mentions.

Contestants will have a choice of topics—"The Advantage of Private Medical Care" or "The Advantages of The American Free Enterprise System over Communism." Complete information may be obtained by writing the Association at 185 N. Wabash Ave., Chicago 60601.

Dr. Land Named Consultant

Dr. Francis L. Land, Fort Wayne, has been appointed as a national consultant in general practice to the Surgeon General of the United States Air Force. He will assist in the surveillance of the Air Force Medical Service and advise the surgeon general when developments in general practice warrant changes in medical service operations.

Pfizer Laboratories Announces Continuance of Scholarships

Pfizer Laboratories will continue their medical school scholarship grants for the school year 1964-65. Each year since 1962, Pfizer has provided one $1,000 scholarship to each of the 86 medical schools in the United States.

The grants are awarded by the individual deans on the basis of scholastic record or financial need, or on other criteria as determined by each school. In addition to this program Pfizer provides AMA-ERF with $100,000 each year for the student loan guarantee program.

Two Indiana Physicians Are Awarded Grants for Research

Two members of the faculty of Indiana University School of Medicine have been awarded grants from the AMA Research Foundation in connection with its program of research on tobacco and health.

Dr. Stuart Bondurant has been awarded $22,200 to seek identification of agents in tobacco smoke which produce changes in the surface tension of the film lining lung alveoli. Knowledge obtained in this study may contribute to an understanding of the factors dealt with in emphysema.

Dr. Wheldon H. Steiner has received $29,040 to study the reaction of blood vessels of the brain to inhaled smoke and to injected nicotine.

APhA Issues Michigan-Inspired Hazardous Substance Labels

The American Pharmaceutical Association has announced the availability of kits of hazardous substance warning labels for distribution to the general public. Originally conceived and designed by the Michigan State Pharmaceutical Association earlier this year, the distinctive red and yellow labels feature a striking snake design over the words, "WARNING—keep out of reach of children."

Sheets of ten labels of varying sizes will be distributed through pharmacies across the nation. Accompanying instructions explain that the labels should be placed on containers of many household products including drugs, which could be harmful if improperly used. Pharmacies having the labels available can be identified by a distinctive red, yellow and black window poster stating, "POISON-PROOF YOUR HOME NOW," which comes in the new kit.

The snake symbol first attracted national attention in March 1964 during National Poison Prevention Week when a story in *Time* magazine brought a flood of requests for labels from government officials, the military, industry and civic leaders as well as from physicians and pharmacists.

A departure from the time-honored skull and crossbone symbol of danger, Francis R. Kronner, MSPA president, said the snake was selected because "television and motion pictures have made the skull and crossbone a too familiar symbol in other fields." The choice of the striking snake forcefully impresses upon children and adults the danger of the substances in a container bearing this label.

New Medical Director at Whiting

Dr. Frank J. Kelly, recently of Richland, Washington, has been appointed chief physician and medical director of the Whiting refinery of the American Oil Company.

Dr. Kelly has been medical director of the

Atomic Energy Commission's Ordnance Plant in Amarillo and most recently was with the Hanford Atomic Products Operation of the General Electric Company in Washington.

Ames Company Announces New Blood Sugar Level Determinant

The Ames Company has announced the introduction of a new, quick and apparently fairly accurate method of determining blood sugar level.

Reagent strips called "Dextrostix" are moistened with one drop of blood obtained by the puncture method, washed off in water after one minute and read by a color chart. Good quantitative results are obtained between levels of 40 and 250 mg. per 100 ml.

Krannert's Donate Funds for Private Patient Pavilion at I.U.

Mr. and Mrs. Herman C. Krannert have made a major gift to Indiana University for the construction of a private patient pavilion in connection with the teaching hospital to be built on the Indianapolis campus.

The 25-bed facility will be named the Krannert Pavilion. The size of the gift was not announced in accordance with the donor's wishes.

However the magnificence of the gift is apparent from the fact that it will provide for the construction of the pavilion and a proportionate share of all central services in the main building, together with a share of the cost of landscaping and general services, as well as the full cost of the equipment and furnishings for the pavilion.

215 First Year Medical Students Enroll at I.U. Medical School

A total of 215 first year medical students, three more than last year's record class, has been accepted for enrollment in the Indiana University School of Medicine. Included in the class are 22 women, the largest number in an entering class in the history of the school.

The past two years have shown a significant increase in the number of Hoosier applicants to the medical school. The incoming group has the best academic record of any class accepted in recent years, and was selected from more than 1,000 applicants, the largest number to apply since immediately after World War II.

Growing prestige of the school throughout the country is reflected in the large number of applicants from outside the state, even though they know only a few will be accepted. This class includes 17 students from seven other states and one each from five foreign countries—Hong Kong, Cuba, Kenya, Canada and Nigeria. The remaining 193 are from Indiana.

The Indiana University Medical School for the past two years has admitted the largest freshman classes, and now ranks among the three biggest medical schools in the country.

Dr. Doan Appointed Director

Major General Howard (Pete) Doan, recently retired from the U. S. Army, has been appointed the director of the AMA Department of Hospitals and Medical Facilities.

Dr. Doan is known to many Hoosier physicians. He was Deputy Surgeon General of the Army from 1961-63 and was executive director of Medicare from 1963 to the present. In 1952-53 he was the Commander of the Army Hospital at Camp Atterbury and was the guest of the ISMA on many occasions during his tour of duty in Indiana.

AEC Publishes Booklet on Emergency Radiological Procedures

The Atomic Energy Commission has published a booklet which tells what to do if radioactive materials are involved in accidents during shipment. The booklet, in its introductory paragraphs, seeks to place radiological hazards in perspective with other hazards.

Copies of the booklet may be purchased from the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402, for 35 cents a copy.

Dr. Bibler Attends Conference

Dr. Lester D. Bibler attended a conference on Family Practice at Temple University School of Medicine, Philadelphia, Pennsylvania in August.

Bloomington Ph.D. to Speak

James E. Counsilman, Ph.D. of Bloomington and head swimming coach for Indiana University and U. S. Olympic swimming coach, will speak at a luncheon session of the Conference on Medical Aspects of Sports on November 29, in conjunction with the AMA Clinical Convention at Miami Beach.

Deadline Announced for SAMA-Eaton Medical Art Awards

The Student American Medical Association announces the competition in 1965 for the SAMA-Eaton awards for medical art. Medical students, interns and residents will compete for one set of awards and professional photographers and students of medical illustration compete for another. Awards will be given in three categories—photomicrography, medical photography and medical illustration. Deadline for entries is December 15, 1964.

The 1965 SAMA Scientific Forum will also feature prizes for student and house staff scientific papers on original research. This contest is supported by a grant from Mead Johnson Laboratories. Deadline for entries is January 1, 1965.

Medical students, interns and residents will also be eligible in the scientific exhibit contest. SAMA-Squibb awards will be made to three students and to three doctors in the house staff category. Deadline for receipt of applications is January 29, 1965.

Further information may be obtained by writing SAMA, 333 N. Michigan Ave., Chicago, 60601. ◄

INDIANA STATE BOARD OF HEALTH

MONTHLY REPORT — August, 1964

Disease	Aug. 1964	July 1964	June 1964	Aug. 1963	Aug. 1962
Animal Bites	848	1304	1139	1019	955
Chickenpox	28	125	203	40	16
Conjunctivitis	81	181	173	48	50
Diphtheria	0	1	0	0	0
Dysentery, Unspecified	51	58	65	270	29
Gonorrhea	351	367	322	323	Not Available
Impetigo	240	252	130	135	119
Infectious Hepatitis	24	46	39	47	31
Infectious Mononucleosis	15	45	58	14	8
Influenza	283	217	120	105	221
Measles (Rubeola-Rubella)	133	548	2358	111	55
Meningitis, Meningococcal	3	3	2	0	2
Meningitis, Other	4	4	4	7	0
Mumps	158	270	467	86	35
Pertussis	29	79	52	62	51
Pneumonia	118	135	173	64	39
Poliomyelitis	1	1	0	0	1
Streptococcal Infections	345	513	433	219	244
Syphilis					
Primary & Secondary	4	7	5	1	Not Available
All Other Syphilis	109	126	102	100	Not Available
Tinea Capitis	6	6	9	3	0
Tuberculosis (Active)	110	135	90	142	149



FUTURE MEETINGS, SEMINARS, COURSES

Congress of Pan-Pacific Surgical Association to be in Three Parts

The Tenth Congress of the Pan-Pacific Surgical Association will be held in three parts. Part I will meet in Honolulu on September 20-28, 1966.

Part II will consist of a Mobile Educational Seminar from September 28 to October 10, in Japan and Hong Kong. Part III will be from September 28 to November 1, in Japan, Hong Kong, The Philippines, Thailand, India, Singapore, Australia and New Zealand.

Further information may be obtained by writing the Association, Room 236, Alexander Young Building, Honolulu, Hawaii 96813.

Workshop in Teratology Set At University of California

A Workshop in Teratology will be conducted by the Drug Research Board of the National Academy of Sciences at the University of California in Berkeley, on January 25 to 30, 1965.

The Drug Research Board is the functional successor to the Commission on Drug Safety which conducted the first such workshop recently at the University of Florida. Further details may be obtained by writing Dr. C. W. Asling, Department of Anatomy, University of California, Berkeley 94720.

SMA Section of Ophthalmology Announces November Meeting

The Section of Ophthalmology of the Southern Medical Association meeting at Memphis on November 16 to 19 will present an outstanding scientific program.

Cataract and muscle surgery, retinal detachment surgery, tonometry, neuro-ophthalmology, photocoagulation, cryosurgery, keratoplasty and fundus lesions will be discussed by experts. Write Dr. George S. Ellis, 812 Maison Blanche Bldg., New Orleans 16, for further information.

Areawide Health Facilities Planning Conference Is Set

The First National Conference on Areawide Health Facilities Planning will be held in Bal Harbour, Florida, Nov. 28 and 29, under the sponsorship of the AMA Council on Medical Service.

The meeting is being held to gain insight and understanding into the growing need for health facilities planning.

AMA Conference on Blood and Blood Banking to be in December

The AMA Conference on Blood and Blood Banking will be held on December 11 and 12, in Chicago, at the Drake Hotel. State and local medical societies are invited to send representatives.

One of the sessions will be moderated by Dr. Clyde Culbertson of Indianapolis. Further information is available from the Department of Environmental Health, 535 N. Dearborn St., Chicago 60610.

Cincinnati College of Medicine Sets Second Annual Postgraduate Course

The Department of Pediatrics of the University of Cincinnati College of Medicine will give its second annual Postgraduate Course in Pediatrics on May 24 and 25, 1965. This course, entitled "Pediatric Aspects of Surgery in Childhood," will be devoted to advances in diagnosis of pediatrics surgical problems and in the pre- and postoperative care of children. In addition to a series of lectures, the course will feature a series of informal small group sessions of five to six participants on related topics and recent advances in general pediatrics.

Registration will be limited to 50 physicians. The registration fee is $50.00.

Address all inquiries to Dr. William Schubert, The Children's Hospital, Cincinnati 29, Ohio.

Indiana Academy of General Practice Lists Lilly Road Shows

Three Lilly Road Shows have been scheduled by the Indiana Academy of General Practice.

The first will be October 28 at Muncie; the second, November 5 at Elkhart and the third December 1 at Fort Wayne. All programs will follow the usual pattern with lectures from 3 to 5 p.m., then dinner, followed by two other one-hour lectures. ◄



I think the doctor is fond of me . . . he wrote "love and kisses" in my stitches.

County News

Benton

Dr. A. L. Coddens, Earl Park, has been re-elected president of the Benton County Medical Society. Dr. William Altier, Fowler, is the vice-president for 1964 and Dr. D. L. McKinney, secretary-treasurer.

Cass

The Cass County Medical Society met Sept. 1 and arranged for the institution of the "Precinct Action Course" provided by AMPAC.

Hendricks

Field Secretary Robert Amick met with the Hendricks County Medical Society Sept. 8 to report on King-Anderson legislation and what is being done by county medical societies in the state.

Howard

The Howard County Medical Society met Sept. 1 to hear Dr. Shokri Radpour speak on "New Advances in Middle-ear Surgery." There were 35 members present.

Lawrence

The Lawrence County Medical Society met Sept. 2 and decided to hold election of officers in the spring. The present officers will carry over until that time. There were 15 members present.

Orange

A discussion of the blood bank problem in the county highlighted the Sept. 1 meeting of the Orange County Medical Society. There were nine members present.

Shelby

The Shelby County Medical Society met Sept. 2 with 18 members present. Dr. Wilson L. Dalton was elected ISMA delegate and Dr. Robert P. Inlow, alternate, at the meeting.

Vanderburgh

Dr. Francis Zeier of the Welborn Clinic discussed his two trips aboard the Hospital Ship Hope with the Vanderburgh County Medical Society at its meeting Sept. 8.

Vigo

Field Secretary Amick met with the Vigo County Medical Society Sept. 8 to discuss King-Anderson, the ISMA Annual Meeting and other items of interest. There were 18 members present. ◄

How Much Is Your Freedom Worth?

I-HOPE believes that physicians and others dedicated to the cause of freedom have enough interest in Americanism to contribute voluntarily to a program devoted to maintaining our way of life

INDIANA HEALTH ORGANIZATION
I HOPE
FOR POLITICAL EDUCATION

INDIANA HEALTH ORGANIZATION FOR POLITICAL EDUCATION

You have a stake in your future, your children's future and your patients' future. Contact your I-HOPE board member to offer your assistance.

test yourself

How much does the average American spend each year on these?

TOBACCO	ALCOHOL	R_X DRUGS
		
☐ $19	☐ $36	☐ $141
☐ $63	☐ $84	☐ $76
☐ $42	☐ $57	☐ $13

Score yourself 100% if you checked the bottom figure in each column. Yes, the U.S. Department of Commerce reports that 1962 per capita expenditure was $42 for tobacco, $57 for alcohol, only $13 for prescription drugs. That's about 25 cents per week per person for drugs that helped them stay well, get well, or possibly helped save their lives. Can you think of a bigger bargain?

Your patients might like to take this test, too. May we send you 25 copies for your waiting room?

Pharmaceutical Manufacturers Association — 1411 K Street, N.W., Washington, D.C. 20005

This message is brought to you as a courtesy of this publication on behalf of the producers of prescription drugs.

Deaths

Elmer Funkhouser, M.D.

Dr. Elmer Funkhouser, a specialist in internal medicine, died Aug. 23 in an Indianapolis hospital. He was 79.

On the staffs of Community, Methodist and St. Vincent's Hospitals, Dr. Funkhouser had practiced medicine for 49 years. He taught bacteriology and pathology at I.U. Medical Center before and after World War II and served for a number of years as head of the pathology department at General Hospital. He was a Senior Member of ISMA and member of the Marion County Medical Society.

Clarence J. Haslinger, M.D.

Dr. Clarence J. Haslinger, 60, Indianapolis physician for 28 years, died Sept. 10 at his home.

Dr. Haslinger, a lifelong resident of Indianapolis, was graduated in 1935 from the Indiana University School of Medicine. He was a member of the Marion County Medical Society and the American Academy of General Practice.

John F. Kelly, M.D.

Dr. John F. Kelly, 63, former Indianapolis physician, died Aug. 23 at Marion.

Dr. Kelly, a Vincennes native, had been on the staff of the Veterans Administration Hospital there for the past five years. He practiced obstetrics and gynecology in Indianapolis for 30 years before moving to Marion.

Ernest Rupel, M.D.

Dr. Ernest Rupel, former president of the State Board of Health, died Sept. 2 in an Indianapolis nursing home. He was 72.

Dr. Rupel specialized in urology for 38 years before his retirement in 1957. He was formerly chief of the urological service at General Hospital. Graduated from the I.U. School of Medicine in 1918, Dr. Rupel served as visiting urologist at I.U. Medical Center hospitals and Methodist and St. Vincent's Hospitals in addition to his duties at General.

Member of the Marion County Medical Society, Dr. Rupel was formerly chairman of ISMA's committee on Scientific Exhibits, a member of the editorial board, ISMA delegate and chairman of the surgical section. ◄

In the December Journal

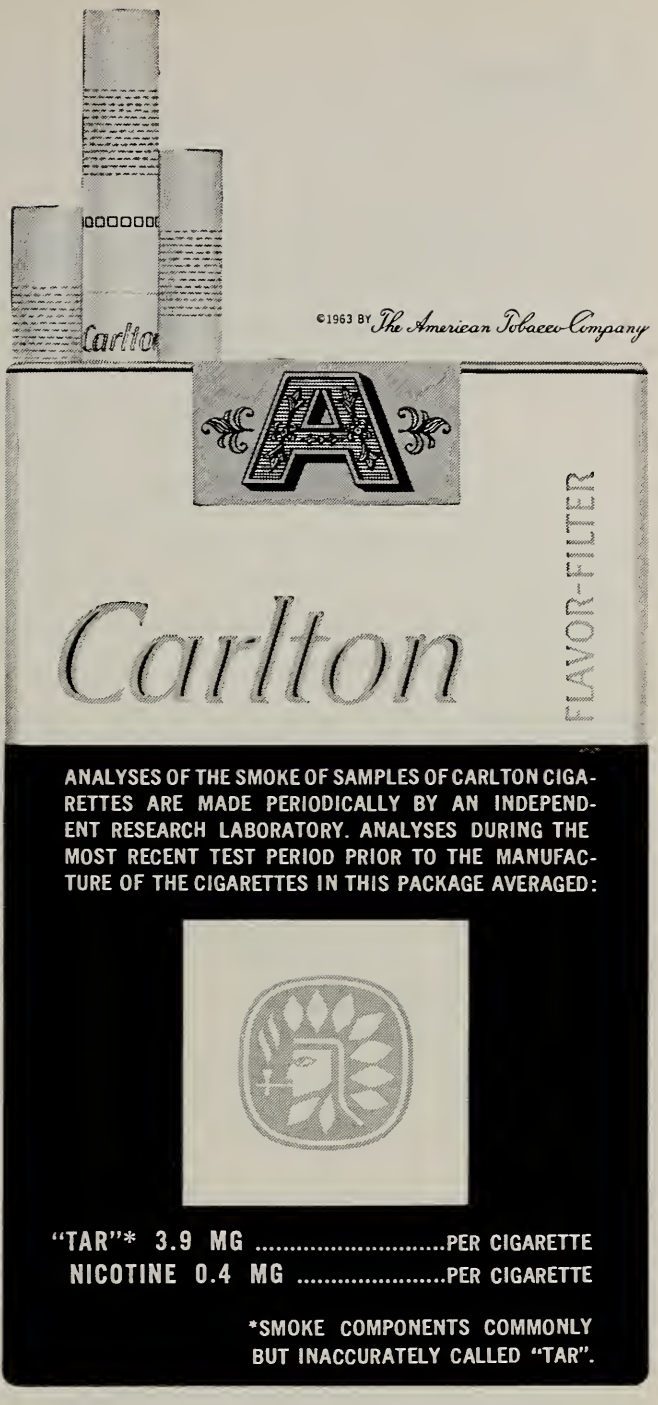
Complete coverage of the 1964 ISMA Annual Convention, including business proceedings of the House of Delegates and a picture story of convention events.

Air vents in the filter.

Carlton—the first cigarette to combine distinctive blend, high porosity paper, and a new flavor-enriching filter with activated charcoal and precision air vents.

Test results on the pack.

On every pack, on every carton of Carlton are printed latest "tar" and nicotine test results as determined in periodic analyses by an independent research laboratory.



Carlton. Low in "tar" and nicotine, high in smoking pleasure. The lightest smoke of all. A cigarette in the tradition of...

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NOVEMBER 1964

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Office of Publication

3935 N. Meridian, Indianapolis, Indiana

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EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members. Cost of color illustrations must be shared by the author.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible. However, the right is reserved to reduce in length or reject any article.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication in THE JOURNAL of the Indiana State Medical Association.

Communications dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 1802 North Illinois Street, Indianapolis 2, Indiana. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 3935 N. Meridian, Indianapolis 8.

Advertising rates will be furnished on request. Copy must be received by the 5th of the month preceding month of issue. (Scientific manuscripts must be received at least two weeks earlier if geared for a specific issue.)

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About Our Cover on page 1235.



Of 507 patients with confirmed ear, nose and throat infections... 465 or 91.7% were treated successfully with Signemycin®

Note:
Adams,* whose 50 patients included 20 with ENT infections, stated that Signemycin "was particularly valuable in infections that did not respond to other antimicrobial agents, and in patients to whom penicillin could not be given." All his cases responded within five days; in most patients, all signs of infection disappeared in three days.

*Adams, J.: J. Tenn. Med. Ass. 50:446, Nov., 1957.

Condition	No. of Patients	No. Cured with Signemycin
Otitis media	90	86
Pharyngitis and laryngitis	162	148
Sinusitis	68	55
Tonsillitis and peritonsillitis	163	153
Various	24	23
Totals	507	465 (91.7%)

consistently effective...often when others fail

Signemycin®

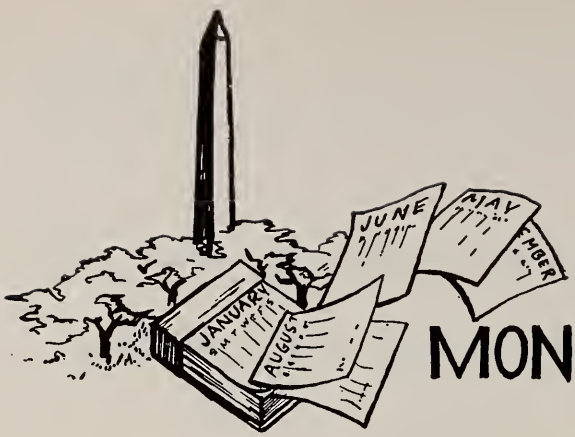
tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

Also available as Syrup, Pediatric Drops, and half-strength Capsules

Brief Summary and Bibliography follow.

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This summary of what is happening in Washington is prepared by A.M.A.'s Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

MONTH IN WASHINGTON

WASHINGTON, D. C.—A House-Senate conference committee deadlocked over the Johnson Administration's so-called Medicare proposal before adjourning to campaign for the November elections.

It meant the death of such legislation for this year unless Congress should be called back in special session after the elections for further consideration of the legislation by the conference committee.

However, Medicare supporters said they would revive the issue next year and make another attempt to get Congressional approval for hospitalization for the aged financed by a Social Security tax increase.

Failure of the committee to reach agreement on Medicare also killed a cash increase in Social Security benefits. The House overwhelmingly voted for the cash increase. The Senate voted 49-to-44 to add an administration proposal that would have financed some hospitalization and nursing home care for the aged under Social Security.

A majority of the House conferees—Ways and Means Committee Chairman Wilbur D. Mills (D., Ark.), Reps. John W. Byrnes (R., Wis.) and Thomas B. Curtis (R., Mo.)—stood pat against Medicare. Democratic Reps. Cecil R. King (Calif.) and Hale Boggs (La.) voted for it.

Four of the seven Senate conferees voted for Medicare to the last in the conference. All Democrats, they were Sens. Clinton P. Anderson (N. Mex.), George A. Smathers (Fla.), Russell B. Long (La.) and Albert Gore (Tenn.). Opposing Medicare were Finance Committee Chairman Harry F. Byrd (D., Va.) and Sens. John J. Williams (R., Del.) and Frank Carlson (R., Kan.).

The conferees from each the Senate and the House voted as a group with a majority determining how the group vote is cast.

Byrnes pointed out that the pro-Medicare Senate conferees had denied an increase in Social Security cash benefits by refusing to have any bill approved if it didn't include Medicare.

"Adequate cash benefits and Medicare cannot both be financed through a Social Security tax," Byrnes said. "Adoption of the Senate amendment would make it impossible, as a practical matter, to adjust cash benefits in order to meeting increases in the cost of living. Cash benefits under Social Security would be 'frozen'."

Meantime, the federal-state Kerr-Mills is paying part or all of the costs of medical care, including hospitalization, for thousands of aged Americans who need such help.

Payments for medical care under the nation's federally-aided public assistance programs neared the $1 billion mark in 1963—an increase of almost $150 million over 1962, according to recent Health, Education and

Continued on page 1224



Of 5,057 patients with confirmed infections of all body systems... 4,731 or 93.5% were treated successfully with Signemycin®

Note:

The high rate of response to Signemycin in these cases is noteworthy because the totals include many patients with difficult-to-treat infections, many whose infections had proved resistant to other agents, and many who had been treatment failures on other therapy.[1-87] In addition the following criteria were used for the cases cited: (1) only published results were used (2) results were confirmed by clinical and/or laboratory findings (3) patients were cured, not "improved" (4) dosage conformed with current recommendations in the United States (5) no other anti-infective agents were used concomitantly (6) no instance of prophylactic use was included in these tabulations.

Condition	No. of Patients	No. Cured with Signemycin
Ear, nose and throat infections	507	465
Respiratory infections	1,028	954
Gastrointestinal infections	425	387
Genitourinary infections	748	684
Skin and soft-tissue infections	1,088	1,036
Bone and joint infections	71	64
Deep-seated or generalized infections	257	251
Obstetrical & gynecological infections	341	320
Miscellaneous conditions	592	570
Totals	5,057	4,731 (93.5%)

consistently effective...often when others fail

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tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

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Continued

Welfare Department figures.

Almost three-quarters of the total--nearly $745 million—was for medical assistance to the aged under the Kerr-Mills Old Age Assistance (OAA) and Medical Assistance for the Aged (MAA) programs. These costs alone increased by nearly $110 million over 1962.

Medical Assistance for the Aged totalled $330 million, an increase of $79 million over 1962, while medical care costs for recipients of Old Age Assistance totalled $415 million, an increase of $31 million over 1962. The MAA program covers the aged who can provide for themselves ordinarily but need help on their medical expenses. The OAA program provides medical care for the aged on public welfare rolls.

Total costs of medical care in 1963 for the needy aged, blind, disabled, and families with children totalled $964,276,000, a large percentage of which was paid for hospitalization.

The figures for 1963 showed that for the federally-aided programs:

—Hospital bills accounted for about 40% of the expenditures, or $384,888,000, an increase of $52 million over 1962.

—Nursing homes received $333,867,000, an increase of $62 million over 1962.

—Physicians were paid $88,942,000, increased $7 million.

—Dentists received $21,203,000, increased $3 million.

—Drug payments totalled $89,216,000, increased $12 million.

—Various other services such as optometrists, pediatrists, special medical supplies, etc. totalled $46,072,000.

Medical care for needy children and their parents accounted for $111.7 million or $15 million over 1962. Recipients of aid to the permanently and totally disabled received medical care benefits of $97.9 million in 1963, about $21 million more than 1962; and aid to the needy blind medical care reached $10.8 million, an increase of $1 million.

Expenditures under the Kerr-Mills program, which was enacted late in 1960, are running much higher now than in 1962 because more states have the program in operation and its benefits have been expanded by some of the states that were among the first to start it. Kerr-Mills MAA expenditures totalled about $36.3 million for 185,641 aged patients in July, 1964.

Kerr-Mills programs were in operation by the fall of 1964 in 38 states and four other jurisdictions: Alabama, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Hawaii, Idaho, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Nebraska, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming, Guam, Puerto Rico, the Virgin Islands and the District of Columbia.

Four other states—Georgia, Indiana, Mississippi and New Mexico—have authorized MAA programs. It will begin in Indiana on January 1, 1965 and is scheduled to start in Rhode Island by then.

The states themselves gave favorable reports on their experiences with the Kerr-Mills program. For instance, Gov. George Romney of Michigan, one of the first states to start a Kerr-Mills program, told the Senate Finance Committee that his state "is proud of its MAA program and of our efforts

Continued

"If food makes him feel good, it is not at all surprising that he will turn to it when times are tough, and his tension mounts."[1]



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Each capsule contains Dexedrine® (brand of dextroamphetamine sulfate), 15 mg., and Compazine® (brand of prochlorperazine), 7.5 mg., as the maleate.

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Side effects (chiefly nervousness and insomnia) are infrequent, and usually mild and transitory.

Cautions: 'Eskatrol' *Spansule* capsules should be used with caution in the presence of severe hypertension, advanced cardiovascular disease, or extreme excitability. There is a possibility, though little likelihood, of blood or liver toxicity or neuromuscular reactions (extrapyramidal symptoms) from the phenothiazine component in 'Eskatrol' *Spansule* capsules.

Contraindications: Hyperexcitability, hyperthyroidism.

Before prescribing, see SK&F Product Prescribing Information.

Supplied: Bottles of 50 capsules.

1. Dorfman, W., and Johnson, D.: *Overweight Is Curable*, New York, The Macmillan Company, 1948, p. 16.

Smith Kline & French Laboratories SK&F

to provide better medical and hospital services for our senior citizens."

Romney's letter was prompted by charges that Michigan's Kerr-Mills program is inadequate, does not reach enough people and is too heavy a financial burden for the state. The charges were made by HEW Assistant Secretary Wilbur Cohen. Romney cited facts to show that none of Cohen's charges were justified.

To inform the public on the broad range of health care available under Kerr-Mills to aged persons unable to pay for it themselves, the American Medical Association, in cooperation with state and county medical societies, conducted a nationwide educational program.

The educational program included explanations by physicians to patients, newspaper and magazine ads and television and radio broadcasts. Much of it coincided with Community Health Week, Oct. 18-24.

GOVERNMENT INVESTIGATES MORE DRUGS

The government has started an investigation of thousands of drugs in an effort to determine if some of them should be removed from the market.

Drug law amendments approved by Congress in 1962 established Oct. 9, 1964, as the deadline for submission by drug manufacturers of evidence that their products are effective.

Food and Drug Administration officials expect some of the drugs to be ruled off the market as worthless and others to be required to change their labels. The investigation is expected to take three or four years. It will encompass all drugs marketed since 1938 with the possible exception of a group involved in a court case in Wilmington, Del.

FDA Medical Director Joseph F. Sadusk announced that 13 categories of drugs have been given priorities in the investigation. On top of the priority list are nutritional drugs called proteolytic enzymes which come in the form of pills and injections. Others on the priority list are fertility drugs, tranquilizers, iron preparations, pediatric drugs, antibiotic combinations, bioflavonoids, hormone creams, drugs used in pregnancy, antihistamines and local anesthetics. ◄

Legislative Roundup

The 88th Congress in Review Adjourning on Saturday, October 3, the 88th Congress passed into history. By almost any measure, the 88th had a busy and eventful two-year term. Approximately 20,000 bills had been introduced in the House or Senate. Of these, 850 affected medicine, medical care or the public health. The AMA presented its views on pending legislation on 25 occasions as well as providing 16 informational statements to various committees of Congress It took nearly 61,000 pages in the *Congressional Record* to record the 88th Congress' deliberations of the various proposals which came before it. In addition, many more thousands of pages of testimony were recorded in the published proceedings of the public hearings which were held in connection with pending legislation. For example, the hearings of the House Ways and Means Committee on H. R. 3920, the King-Anderson bill, filled five volumes and ran to over 2,500 pages.

Some of the more major measures of medical interest which were enacted into law were: the Health Professions Educational Assistance Act which provides construction grants for the construction of teaching facilities and a student loan program; Maternal and Child Health and Mental Retardation Planning Amendments providing grants to help meet the cost of special projects, research and other activities; Mental Retardation Facilities and Community Mental Health Centers Construction which authorizes grants for the construction of research and clinical facilities and for community mental health centers; Clean Air Act expanding the federal government's role in air pollution control; Hospital and Medical Facilities Amendments which extended for five years the Hill-Burton hospital construction grant program and adding to it, grants for the modernization of existing facilities and for areawide health facilities planning programs; and the Nurse Training Act authorizing grants for the construction and modernization of nursing schools and establishing a loan fund for student nurses.

Several other bills of interest to medicine failed to gain approval of both houses of Congress, and died with the adjournment of the 88th Congress. Included were: a water pollution control measure; reorganization of the U.S. Public Health Service; the creation of an "Office for Senior Citizens" in the Department of Health, Education and Welfare; the King-Anderson medicare-tax proposal; chiropractic care for federal employees under the Federal Employees' Compensation Act; a psychotoxic drug control program; and a bill which would have exempted nonprofit blood banks from the antitrust laws.

Council on Legislative Activities,
American Medical Association



and it's not a once-over-lightly one, either. All rubber stoppers used in Lilly ampoules are scrupulously cleaned with a detergent and hot deionized water in a special washing machine like the one pictured above. This removes any foreign matter adhering to them. Then the stoppers are autoclaved at 120° to 121°C. for one hour. They are now clean, sterile, and ready for use. In case the stoppers are not used within seventy-two hours, they are returned for resterilization. □ This meticulous process is only one of the many safeguards to insure the quality of the finished product and to protect the ultimate user.

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Psychopharmacologic Survey of Psychiatric Referrals

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THE NON-PSYCHIATRIST physician and the public have both become more aware of mental disorders in the past decade. The development of effective psychopharmacologic drugs, the publication of voluminous accounts of psychiatric research in general medical journals, and the sponsorship of postgraduate courses in psychiatry have made the non-psychiatrist physician more informed of the emotional problems among his patients and pointed out therapies he might use. Furthermore, mental health campaigns and the preoccupation of the mass media with psychiatric themes have led the public to greater interest and acceptance of psychiatric treatment.

A physician uses his position as a medical authority to advise, reassure and counsel—although more often now-a-days the non-psychiatrist physician relies on drugs to modify the symptoms of emotional patients. Since it had been my observation that referrals to a psychiatrist often represent difficult cases for diagnosis and management, I felt an examination of treatment prior to referral would indicate in what areas the non-psychiatrist physician could improve his effectiveness in managing emotional disorders and in what areas postgraduate education in psychiatry is needed for the non-specialist.

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I reviewed referrals that had been sent to me for psychiatric evaluation and/or treatment during the last part of 1962 and early 1963. My patients are probably typical of those any Midwest general psychiatrist in private practice would see. All of the patients lived in central Indiana with 88% from Indianapolis or Marion County. Nearly all of them were from urban areas. All the patients at time of referral were under the care of a physician or had been under such care in the recent past.

One hundred forty-one cases were used as a basis for this study; 133 remained after eight were discarded because of insufficient history. All patients, as well as a member of their family in most cases, were interviewed by me. Reliability was good and there were few discrepancies between the patient's history and the collateral history of the family. When there was a difference, the statement of the more reliable person was chosen.

At the interviews these questions were investigated: (1) What was the source of their motivation to be seen by a psychiatrist? (2) Did they take their medications as directed? (3) How did they depart from the prescribed drug regimen? (4) What diagnostic categories were not treated with drugs by their attending doctor? (5) In what ways did the attending doctor use drugs ineffectively? (6) Was there any

relationship between the appropriateness of the medication prescribed and the reliability of the patient to take his medication as directed?

Often the patients had multiple sources of motivation to seek psychiatric help, but only the stronger or the most immediate reason for seeking help was listed. Patients were considered to have taken their medication as directed if they did not depart from their prescribed dosage more than 25% on any given day.

The decision as to whether or not a drug was being used effectively was sometimes difficult to make. An attempt was made to conform to current standard psychiatric practices and to avoid arbitrary or personal preferences. For the sake of completeness, minor as well as major deviations from appropriate prescribing were listed.

Results

The family doctor in the majority of cases (64%) was the one to point out to the patient his emotional problems, and to convince him that he needed to consult a psychiatrist (Table I). Interestingly, the next largest source of referrals came from a governmental agency, the Social Security Disability Section. My sample may be overrepresented by Social Security Disability applicants who conceivably might be less motivated for treatment that the others. Surprisingly, only six percent were self-motivated. The courts requested six percent see a psychiatrist while the church, school, family and friends persuaded nine percent to seek treatment.

Source of Motivation to See a Psychiatrist

	Cases	%
M.D.'s	85	64
Social Security Disability	20	15
Self	9	6
Legal	8	6
Church or school	6	5
Family or friends	5	4
Total	133	100

Table I

Ninety-three of the 133 cases had been placed on some type of pharmacologic regimen by their physician before their psychiatric evaluation. Three of the patients improved while taking medication after the time of referral and prior to being seen. The other 90 felt no improvement from the medication and were considered therapeutic failures by the prescribing physician.

These 90 patients were classified into three groups in regard to how well they took their medication prescribed by the referring doctor (Table II). Disillusioning was the finding that only 43% gave a clear history of taking their medication as directed.

Patient Reliability in Taking Drugs

	Cases	%
Took medicines as directed	39	43
Did not take medicines as directed	40	45
Patients who were suspected of major deviations or admitted minor deviations	11	12
Total	90	100

Table II

The 40 patients who did not take their medication as directed fell into almost equal groups, 22 took excessive amounts and 24 discontinued or took less than therapeutic amounts. There was some overlapping of the groups caused by patients who, at different times, overdosed and underdosed themselves. The overdosage group was made up of 11 who made suicide attempts with their medication, four who increased their dosage in an effort to control their symptoms, three who became habituated, three who took additional medicine not prescribed by the attending physician and one who became addicted (Table III).

Overdosage Group

	Cases
Suicide attempts	11
Excessive use	4
Habituation	3
Added other medications	3
Addiction	1
Total	22

Table III

The underdosage group gave the follow-

ing reasons for not taking their medication: five felt there was no purpose in taking medicine when they were having no symptoms, five complained of the pharmacological side effects of the drug, five complained of side effects almost certainly not associated with the drugs' pharmacological action (negative placebo effect), four feared they would become dependent on or addicted to the drug, three were so paranoid and suspicious they rejected the drug and two discontinued medication for economic reasons (Table IV).

Underdosage Group

	Cases
Took medicine symptomatically	5
Side effects	5
Negative placebo responses	5
Fear of dependency	4
Paranoid	3
Economic	2
Total	24

Table IV

Only 40 of the 133 patients were not on drugs before they were referred for psychiatric evaluation. Their diagnoses are listed below (Table V).

While conceivably, drugs could have been used supportively in many of these 40 cases, the eight schizophrenics and the single manic-depressive seem to have the strongest indications for drugs.

Of this group of 40 cases, only 16 were directly referred by a physician (Table VI).

Direct Referrals Not Treated with Drugs

Diagnosis	Cases
No psychiatric diagnosis (marital problems)	7
Adjustment reaction of adolescence	3
Dissociative reaction	2
Schizophrenia (in a 15-year-old)	1
Antisocial personality disturbance	1
Adjustment reaction of childhood (school phobia)	1
Manic-depressive reaction, manic type	1
Total	16

Table VI

Among the patients not treated with drugs who were directly referred by their attending physician, only two, an adolescent schizophrenic and a manic-depressive, were very good candidates for drug therapy. When the family doctor was aware of the psychiatric problems of his patient and had made a psychiatric referral, he seldom neglected the opportunity to use psychopharmacologic drugs before turning the patient over to a specialist. On the other

Patients Not on Drugs

Diagnosis	Cases
No psychiatric diagnosis (marital problems)	9
Schizophrenia	8
Sexual deviation	5
Adjustment reaction of adolescence	4
Antisocial personality disturbance	4
Dissociative reaction	2
Schizoid personality	1
Conversion reaction	1
Adjustment reaction of adulthood	1
Adjustment reaction of childhood	1
Emotionally unstable personality	1
Chronic brain syndrome	1
Manic-depressive reaction, manic type	1
No psychiatric illness (evaluation for divinity school)	1
Total	40

Table V

Ineffective Uses of Drugs	Cases
Lethal amounts of tranquilizers and sedatives for patients with suicidal rumination or past history of suicidal attempt	11
Minor tranquilizer (meprobamate or chlordiazepoxide) for schizophrenia	10
Sedatives for schizophrenia	5
Antidepressants for schizophrenia	4
Tranquilizers for depression	3
Combination of tranquilizers	3
Use of tranquilizers while ignoring medical illness (cholelithiasis and hypertension)	2
Overdosage (oversedation and pseudoparkinsonism)	2
Potentially lethal combination of antidepressants	2
Total	42

Table VII

hand, seven schizophrenics had to find encouragement outside a medical setting to seek psychiatric help. It is not clear whether the family doctors of these seven schizophrenics did not recognize them as being mentally ill or did not want to become involved in recommending psychiatric treatment or making a psychiatric disposition.

Sixty-four patients had 42 ineffective medications prescribed for them. Table VII lists the ineffective ways psychopharmacologic drugs were used.

Eleven patients attempted suicide with their medications, the most popular method for self-destruction in this group of patients. Fortunately none were successful. Lethal quantities of medicine were not difficult to obtain either from a single prescription, by hoarding or by combining medicines received from more than one doctor. The suicide attempts should not have been a surprise to the prescribing physicians because all 11 patients had made previous attempts at suicide with drugs or were having thoughts of suicide at the time they were given the medication. All of these patients talked freely about their suicidal ruminations.

Fifteen schizophrenics were treated inappropriately with a minor tranquilizer (10) or sedatives (five). It is assumed that these cases were not investigated thoroughly or the severity of the mental disturbance underestimated. The referring doctors also had considerable trouble differentiating schizophrenia from depression with four schizophrenics being treated with antidepressants while three depressions were treated with tranquilizers. Three patients with high levels of anxiety were unsuccessfully treated with small doses (less than the manufacturer's recommended dosage) of different tranquilizers in combination.

The number of patients whose emotional symptoms were treated to the neglect of their medical problems was very small (only two). Serious overdosage was also infrequent (two cases). One patient on a minor tranquilizer was oversedated and represented a danger to herself and others when she drove her automobile. Another patient on a phenothiazine was very uncomfortable with the following side effects: rigid posture and gait, drooling, thick speech and spasmodic torticollis. The combination of a non-monamine oxidase inhibitor with a MAO inhibitor antidepressant, a potentially lethal combination, was discovered only twice. Fortunately neither patient reported serious complications.

Another 30 ineffective non-psychopharmocologic drugs were used for emotional disorders (Table VIII).

In a good many instances medications were given without objective evidence that an organic condition warranted their use, such as: vitamins in cases where there was no vitamin deficiency, thyroid for euthyroid patients, anticonvulsants for people not having seizures, hormones for women not suffering from menopausal symptoms, iron for patients without anemia and a cholinergic drug to a female patient who did not have myasthenia gravis. Five patients found their levels of anxiety raised

Non-psychopharmacologic Drugs for Psychiatric Disorders	Cases
Vitamin injections for schizophrenia 1, depression 2, psychophysiological reactions 2	5
"Diet pills" (amphetamine) for schizophrenia 2, emotionally unstable personality 3	5
Thyroid for depression 3, obesity 1, schizophrenia 1	5
Anticonvulsants for personality disorders	4
Narcotics for psychophysiological reactions	4
Female hormone injections for depression 1, schizophrenia 3	4
"Liver and iron" for depression	2
Cholinergic drug for psychophysiologic reaction	1
Total	30

Table VIII

to dangerous levels by the treatment of "fatigue" or obesity with amphetamines. These five patients had such chaotic and unstable past histories that an untoward response to amphetamines might have been predicted. Four patients received narcotics for prolonged periods of time without adequate diagnosis to explain the distress.

Table IX compares the effect of appropriateness vs. inappropriateness of medication upon the tendency of the patient to follow the prescribed directions.

A small difference appears in the direction of patients taking appropriate medications more faithfully than inappropriate drugs, but this is statistically insignificant.

From the psychiatric evaluation and the subsequent course of the patient's illness a judgment was made as to the reason for failure of the patient to improve with drug management in the hands of a non-psychiatrist physician (Table X).

The greatest source of drug failure was inappropriate prescribing although nearly as many patients had chronic illnesses that could not be reasonably expected to improve with medication. Even though 45% of the patients on drugs took them unreliably, only half that number actually figured as the cause for their lack of improvement.

Reasons for Drug Failure	Cases	%
Inappropriate drug	39	43
Patient did not take medication as directed	17	19
Patient's disease	34	38
Total	90	100

Table X

Discussion

This series of patients illustrates many ways the non-psychiatrist physician could improve his handling of patients with psychiatric disorders. First, he could sharpen his screening procedures to recognize the psychiatrically impaired patient, make the patient conscious of his illness and see that he receives treatment.

Physicians ought to be aware of the large percentage of psychiatric patients who will not take their medications reliably.

Appropriateness of Medication vs. Patient Reliability	Appropriate Medication		Inappropriate Medication			
	Cases	%	Cases	%	Total Cases	Total %
Reliable	13	14	26	29	39	43
Unreliable	10	11	30	34	40	45
? Reliable	3	3	8	9	11	12
Totals	26	28	64	72	90	100

Table IX

Particular attention should be paid to the possibility of suicide. Psychopharmacologic drugs should not be given to a patient without inquiring whether or not the patient had ever made a suicidal gesture or had contemplated taking his life. Refillable prescriptions or prescriptions for large amounts of psychopharmacological drugs should be avoided.

Physicians have traditionally given "tonics", vitamins, small amounts of barbiturates and other non-specific medications to patients with varying degrees of "nervousness", personality and/or mental problems. This has been useful in the past for the following reasons: the patient often expects medicine when he consults a doctor, patients are offended and lost to treatment if they are told they have no organic disease and suffer from "nerves" and it gives the physician an opportunity to reassure and support the patient periodically. While a weekly intramuscular injection, a talk with the doctor, and a high expectation of the patient that he will get well undoubtedly has helped many patients, I believe that psychopharmacology has advanced to the stage that we, as physicians, can begin a more specific treatment of emotionally disturbed patients. It is now becoming possible to delineate what type of psychiatric illness a patient has and to select from a large assortment of psychopharmacologically active agents one designed to treat that patient's symptoms.

The dangers of administering drugs to psychiatric patients were not always recognized. The combination of a non-monamine oxidase inhibitor during or shortly after treatment with a monamine-oxidase-inhibitor antidepressant can cause hyperpyrexia, convulsions, vascular collapse and even death. [1,2,3] Antidepressants administered to latent schizophrenics have been known to "uncover" the underlying schizophrenic process and precipitate an acute break.

Amphetamine and other sympathomimetic drugs can be dangerous in treating emotional patients. When used in excessive amounts by relatively stable people, it can produce a psychiatric disturbance similar to paranoid schizophrenia with ideas of reference, paranoid delusions and hallucinatory experiences.[4] In the reintegrated or the latent schizophrenic, a psychosis can be precipated by a well meaning attempt at appetite suppression. Even when the schizophrenic is taking a tranquilizer, amphetamine can produce "increased hostile and paranoid belligerency and thinking disturbance."[5] There would seem to be wisdom in being extremely cautious about using amphetamines as a means of attempting weight control in the emotionally unstable or potentially unstable patient.

The schizophrenic appears to be a particular problem for the non-psychiatrist physician. A total of 34 schizophrenics received inadequate or no treatment—eight had been to their family doctor without psychiatric care or referral, 19 received inappropriate psychopharmacologic drugs and seven received non-psychopharmacologic drugs. Physicians ought to be alert to the fact that bizarre physical symptomatology can represent schizophrenic thinking just as readily as it can an aberrant form of organic disease. Postgraduate courses that present the criteria for making a diagnosis of schizophrenia should be useful.

There is no evidence shown by this study that there was any relationship to the appropriateness of the medication prescribed and the reliability of the patient to take his medication as directed.

Finally, it should be recognized by patient and physician alike that psychopharmacologic drugs, like many drugs used in medicine, primarily act to control symptoms. This means that the problem or conflict that produces the symptoms must be altered before the patient can be withdrawn from drugs and be free of symptoms. Ordinarily this would necessitate a change in the patient's environment or attitudes. Successful drug treatment, therefore, requires that the patient, with or without professional guidance, must modify his previous unsatisfactory manner of dealing with life.

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About Our Cover

As a rescue vehicle, be it on the battlefield or on the home front in an emergency or disaster, the helicopter has no equal.

When accidents occur in our cities and suburbs, ambulances often lose life-saving minutes as they fight the congested highways, freeways and city streets —not to mention the apprehension of the patient as the ambulance races toward the hospital with siren shrieking.

So why not hospital heliports?

Simply by providing a minimum size rooftop landing pad or a roped-off area in a parking lot, lives could be saved. It is becoming more and more difficult for ambulances to get to and from the scene of an accident due to already traffic-jammed highways being further clogged by the curious.

Methodist Hospital does use a roped-off area on its parking lot on Memorial Day as a heliport for landing race drivers injured in the 500 Mile Race. But no other Indianapolis hospital has made provisions for a heliport.

The Flying Physicians Association is trying to interest more hospitals in providing space for hospital heliports. The association was founded in 1954 to promote general aviation safety and to assist in the nation's Civil Defense efforts.

Dr. M. F. McGrath, Indianapolis general practitioner and present state chairman of the Flying Physicians Association, said that "Indianapolis is becoming so spread out that a hospital heliport could be used most effectively here. Community Hospital would be the ideal location," he said.

"There are no surrounding tall buildings out there and very few wires. Community has a large area of ground and any of several sections could be used for a heliport," he added.

There were 29 hospital heliports in the country and three more proposed as of the first of this year.

Following are comments from one hospital administrator on the heliport there: "We are delighted to know there is a growing interest in establishing heliports at hospitals. When Ochsner Foundation Hospital was completed in 1954, a heliport was set up practically before the grass had a chance to grow over the newly graded ground. The value of this small allotment of ground has been brought home to us time and time again; scarcely a week passes that we do not have patients brought to the hospital by helicopter. The speed and comfort of air transport to the hospital has undoubtedly saved lives and definitely has prevented unnecessary suffering"—Josephine M. O'Meallie, Oschner Foundation Hospital, New Orleans, La.

The picture on this month's cover was taken as a critically injured bulldozer operator was lifted in the helicopter litter at the Methodist Hospital Heliport at Arcadia, California. Our thanks to Jean Ross Howard, Assistant Director of the Vertical Lift Aircraft Council, Aerospace Industries Association, for making the picture available to us.—J.F.S.

Routine Blood pH Measurement

LAURENCE P. SKENDZEL, M.D.*
Indianapolis

THE DIAGNOSTIC EVALUATION of patients suspected of having an acid-base imbalance should include measurement of blood pH, in addition to measurement of carbon dioxide content and other electrolytes. Gambino[1] cites several instances in which the CO_2 content of serum was normal, yet pH values indicated alkalosis or acidosis. Cochran[2] also reported two cases in which the estimation of blood pH led to a diagnosis of metabolic alkalosis, apparently due to potassium deficiency in patients with pulmonary insufficiency.

Although the estimation of pH adds greatly in diagnostic accuracy, some laboratories are reluctant to provide these measurements as a routine procedure. The estimation of pH is time consuming since special care is required for the collection, transfer and analysis of the blood specimen. Some physicians too, have little experience in using pH values as a guide to diagnosis or therapy and tend to underestimate their importance.

A study was undertaken at Marion County General Hospital to demonstrate the usefulness of blood pH as a routine laboratory procedure. This paper deals with the pH analysis of 586 samples of blood on which the physicians had requested a CO_2 content. The study provides additional evidence that pH determinations are essential for accurate diagnosis of many respiratory and metabolic disturbances. Illustrative cases are presented.

Materials and Methods

Laboratory technicians collected all the samples of venous blood in heparinized vacuum tubes, which were placed in an ice bucket for transfer to the laboratory. The technicians were instructed to avoid excessive agitation of the tubes and to fill them to ¾ capacity or more, so as to minimize the loss of CO_2 into the air space above the sample. Blood samples were kept at 0-4° C. in the laboratory, prior to measurement of pH. In the majority of instances, pH and CO_2 content were estimated within one-half hour after delivery to the laboratory; in all cases, the studies were completed within one and one-half hours.[3]

A radiometer pH meter with a microglass electrode chain and a circulation thermostat designed to circulate water at 38° C. around the electrode was used for measurement of pH. Buffers† with a pH of 6.840 and 7.381 at 38° C. were used to standardize the instrument. All blood samples were analyzed in duplicate and results were acceptable if they agreed within ±0.02 pH. Between determinations, the accuracy of the instrument was checked with buffers of known pH. The CO_2 content of plasma was estimated with a manometric Natelson microgasometer. A solution of sodium bicarbonate (25 mM/liter) was used to check the accuracy and precision of the procedure.

Blood pH in the range of 7.35-7.45 was regarded as normal in this laboratory. (In a study of normal, fasting, and resting adults, the pH was in the range of 7.38-7.42. Since the precision of the method in our laboratory was ±0.02, the normal range was extended to 7.35-7.45 so that all cases in which pH fell outside these limits could safely be classified as abnormal.) The normal range for CO_2 content is 24-29 mM/liter.

Blood pH was measured on all samples submitted for estimation of CO_2 content. The material for study was collected from a selected group of patients, the majority of whom were suspected of having some electrolyte abnormality. However the physicians who had requested CO_2 content were unaware of the laboratory study.

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† Purchased from the London Company, Cleveland, Ohio.

Results

Blood pH and CO_2 content were estimated on 586 consecutive blood samples collected from 362 patients. The results shown in Table 1 were classified into nine categories on the basis of pH and CO_2 values.[1,4] Cases in which the pH was abnormal and the CO_2 content was within the normal range were classified as unsuspected alkalosis or acidosis. An abnormal CO_2 content with a normal pH was regarded as compensated alkalosis or acidosis.

In 393 blood samples (65%), pH and/or CO_2 content was abnormal. Of the total samples analyzed there were 60 (10%) in which alkalosis was unsuspected and 18 (3%) in which acidosis was unsuspected on the basis of CO_2 content. These cases probably would have escaped detection if pH measurements had not been performed. Compensated alkalosis or acidosis occurred in 183 blood samples and the physician would have been unaware that compensation had taken place since the CO_2 content was either above or below the normal range and the pH was within normal limits. Metabolic alkalosis was found in 38 specimens and metabolic acidosis is 38 specimens. Respiratory alkalosis occurred in 50 specimens, and respiratory acidosis in six instances.

Discussion

Four classical types of disturbances—metabolic acidosis, metabolic alkalosis, respiratory acidosis and respiratory alkalosis—are usually considered in the study of cases with suspected acid-base imbalance. In these disturbances, alteration of pH is always accompanied by an alteration of CO_2 content. Blood pH is not necessarily required for the detection of clinical disorders of acid-base imbalance which fall into these four categories since the CO_2 content along with the clinical findings may be sufficient for diagnosis.

On the other hand, our data lead us to the conclusion that in General Hospital, complex metabolic and respiratory abnormalities occur with sufficient frequency to warrant the routine measurement of pH. In 13% of the specimens, deviations from the normal in blood pH were not accompanied by changes in CO_2 content and blood pH led to the identification of a disturbance in acid-base equilibrium which would have escaped detection if sole reliance had been placed on CO_2 content. Cases in which the CO_2 content was within normal limits and the pH was abnormal were classified as unsuspected alkalosis and acidosis.

It is not within the scope of this paper to discuss at length the mechanisms responsible for acid-base imbalance. However, we have been impressed with the frequency of unsuspected alkalosis. Unfortunately, we do not know the ultimate outcome of the ma-

VALUES OF pH AND CO_2 CONTENT IN 586 SPECIMENS OF BLOOD

Classification	pH	CO_2 Content	Number	Percent
Metabolic alkalosis	High	High	38	6.5
Respiratory alkalosis	High	Low	50	8.5
Unsuspected alkalosis	High	Normal	60	10.2
Compensated alkalosis or acidosis	Normal	High	53	9.1
Compensated alkalosis or acidosis	Normal	Low	130	22.2
Normal	Normal	Normal	193	32.9
Metabolic acidosis	Low	Low	38	6.5
Respiratory acidosis	Low	High	6	1.0
Unsuspected acidosis	Low	Normal	18	3.1

TABLE 1

jority of cases in this category because follow-up studies were not always performed. In eight patients, however, who were studied for several days, unsuspected alkalosis, with a normal CO_2 content and abnormal pH, developed during the transition from metabolic acidosis to metabolic alkalosis. In another group of 15 patients, hypokalemia was the most likely explanation for the imbalance.

All patients with unsuspected acidosis had combined metabolic and respiratory disorders. Several of these were hospitalized in the tuberculosis unit of the hospital and had far advanced pulmonary disease along with renal insufficiency. Congestive heart failure, emphysema and azotemia occurred in other patients in this group.

The present study directs attention to the use of blood pH measurements for the identification of compensated alkalosis and acidosis. In this series, there were 183 blood specimens in which the CO_2 content was either reduced or increased and pH was normal. This would seem to indicate that prior to intensive therapy for correction of respiratory and metabolic disturbances, a physician may utilize pH to determine the degree of acid-base imbalance.

Our experience with the routine analysis of blood for pH is in agreement with the reports of Gambino.[1] In his series of 1,567 specimens, nine percent were classified as unsuspected alkalosis and 13% as unsuspected acidosis.

Although measurement of pH requires additional laboratory effort, we feel that it is time well spent. Once established, the system for collection is quickly adopted by the technical staff. Physicians benefit, in that they are provided with additional information about the acid-base status of the patient.

Case Reports

Case 1. A 79-year-old woman was admitted because of chronic pyelonephritis, anemia and uremia. On admission, metabolic acidosis was revealed by a CO_2 content of 13 mM/liter, pH 7.29, urea nitrogen 75 mg/100 ml and serum chloride 99 mEq/liter (Figure 1). Intravenous therapy was begun and on the second day, the pH was

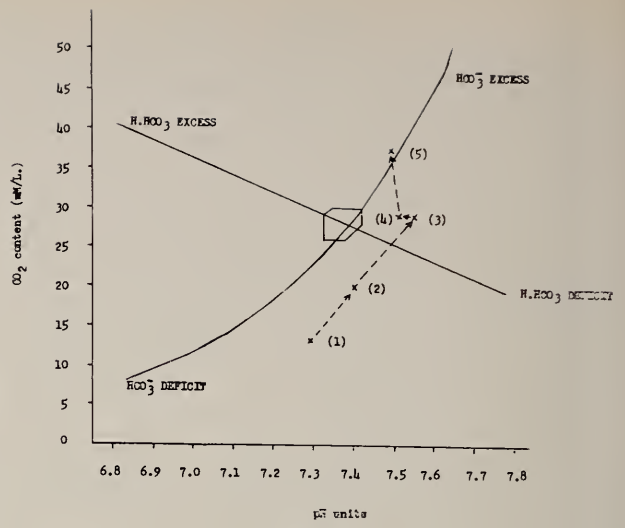


FIGURE 1

NOMOGRAM of pH and CO_2 values from Case 1.

Day 1: pH 7.29, CO_2 content 13 mM/liter, metabolic acidosis.

Day 2: pH 7.40, CO_2 content 20 mM/liter, compensated acidosis.

Day 3: pH 7.53, CO_2 content 29 mM/liter, unsuspected alkalosis.

Day 4: pH 7.51, CO_2 content 29 mM/liter, unsuspected alkalosis.

Day 5: pH 7.49, CO_2 content 37 mM/liter, metabolic alkalosis.

7.40 and CO_2 content 20 mM/liter, indicating compensated acidosis. However, repeated episodes of vomiting occurred during the next three days. On the third and fourth days, the CO_2 content was 29 mM/liter, pH 7.53 and 7.51 and the serum chloride had decreased to 90 mEq/liter. Unsuspected alkalosis persisted until the fifth day, when the patient was found to have a metabolic alkalosis with a CO_2 content of 37 mM/liter, pH 7.49 and serum chloride 84 mEq/liter.

Case 2. A 20-month-old child was admitted because of salicylate intoxication. On admission, the CO_2 content was 8.1 mM/liter and the salicylate concentration was 72 mg/100 ml. A pH was not performed, but it was the clinical impression that the child was in a state of respiratory alkalosis. Fluid therapy consisted of five percent dextrose and water, sodium lactate and potassium chloride. Ten hours after admission, the child was still lethargic and the respiratory rate was 36 per minute. The physician was of the opinion that the child was in a state of metabolic acidosis. Laboratory studies, however, showed that after ten hours of treatment, the CO_2 content was 9 mM/liter and the pH 7.51, indicating the

patient was still in respiratory alkalosis.

Case 3. An 80-year-old man had been seen repeatedly in the clinical department of the hospital because of diabetes mellitus, arteriosclerotic heart disease and episodes of congestive heart failure. The diabetes was controlled with NPH insulin. Physical examination at the time of admission showed marked cardiomegaly, pulmonary edema and bilateral pedal edema. An x-ray of the chest showed chronic pulmonary emphysema and cardiomegaly. The patient had respiratory acidosis with a CO_2 content of 41 mM/liter, and a pH of 7.34 (Figure 2). The urea nitrogen was 36 mg/100 ml. Digitoxin, metahydrin and potassium triplex were given. Laboratory studies performed 13 days after admission showed that the patient's condition had deteriorated; CO_2 content was 35 mM/liter, pH 7.30 and urea nitrogen 78 mg/100 ml. These data point to a metabolic acidosis superimposed on respiratory acidosis. The rising urea nitrogen concentration indicates renal impairment and explains the metabolic acidosis.

Case 4. A 70-year-old man was hospitalized because of chronic bilateral cavitary tuberculosis and urinary obstruction, secondary to adenocarcinoma of the prostate. Laboratory studies showed CO_2 content 25 mM/liter, pH 7.27 and urea nitrogen 70 mg/100 ml. The CO_2 content was within the normal range, but the pH denoted acidosis. The diagnosis was a combined respiratory acidosis due to tuberculosis, plus a metabolic acidosis due to renal insufficiency.

Case 5. A 28-year-old man with a history of alcoholism was admitted because of muscular weakness, leg pains and edema of the ankles and legs. Physical examination was not remarkable, except for hepatomegaly and 3+ pitting edema of the legs. He was found to have metabolic alkalosis with a CO_2 content of 39 mM/liter and sodium content of 140 mEq/liter. The pH was 7.55, serum potassium 1.2 mEq/liter and chloride 88 mEq/liter. The metabolic alkalosis was corrected by intravenous and oral potassium.

Case 6. A 21-year-old man was a poorly controlled diabetic, admitted because of diabetic acidosis. Physical examination was not remarkable. On admission, the blood glucose was 350 mg/100 ml, urinary ketone bodies 4+ and CO_2 content 11 mM/liter. A pH was not performed on admission. Treatment consisted of insulin, sodium carbonate, sodium lactate and potassium triplex. The following day a pH showed the patient to have a metabolic alkalosis with a CO_2 content of 36 mM/liter, pH 7.57, potassium 2.3 mEq/liter, sodium 136 mEq/liter and blood glucose 90 mg/100 ml. After administration of additional potassium, all laboratory studies were repeated and were found to be within normal limits.

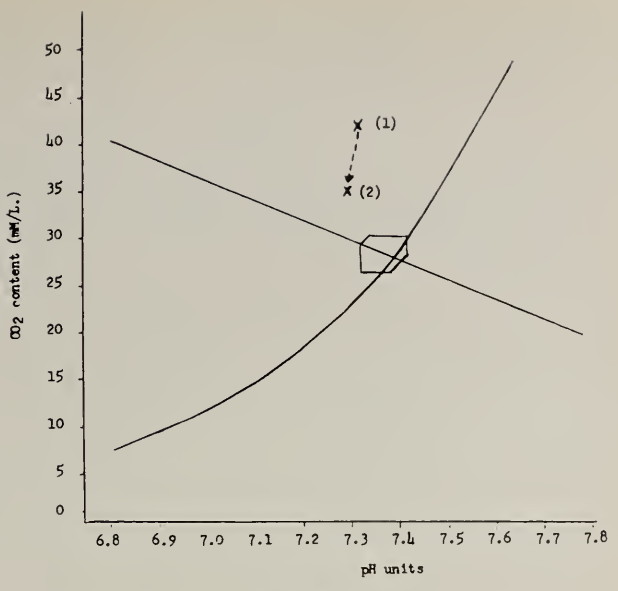


FIGURE 2
NOMOGRAM of pH and CO_2 values from Case 3.
Day 1: pH 7.34, CO_2 content 41 mM/liter, respiratory acidosis.
Day 2: pH 7.30, CO_2 content 35 mM/liter, respiratory and metabolic acidosis.

Summary and Conclusions

This study was undertaken to demonstrate the usefulness of blood pH in the diagnosis of acid-base disorders. Blood pH was performed on 586 samples submitted to the laboratory for evaluation of CO_2 content. In 393 samples, the pH and/or CO_2 content was abnormal. Of greater interest was the detection of unsuspected alkalosis (normal CO_2 content, elevated pH) in 60 instances and unsuspected acidosis (normal CO_2 content, low pH) in 18 blood samples. A normal pH, but abnormal CO_2 (compensated alkalosis or acidosis) was found in 183 samples. The cases of unsuspected and compensated alkalosis and acidosis probably

would have escaped detection without an estimation of blood pH.

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From *The Journal* 50 Years Ago

. . . In summing up the surgical treatment of goiter, we wish to emphasize the following:

1. All cases of goiter producing symptoms which have not improved, or have been made worse by medical treatment, should be operated.

2. The case that does not show improvement by rest, diet and general hygienic treatment, the heart still bad, remaining dilated, kidneys bad, prostration and general muscular weakness marked, mental and nervous balance not reestablished, should not be operated.

3. In acute cases of Graves' disease, if the heart is showing one inch or more of dilatation, the ligation of the superior thyroid vessels should be practiced, to be followed by further surgical procedure as is indicated.

4. Boiling water should be injected into the gland substance if the necessary improvement does not follow ligation.

5. It is possible to operate many goiters under local anesthesia, one-half of one per cent novocain having the best results with us.

6. If a general anesthetic be necessary, none but one well trained should attempt to or be allowed to administer same.

7. Some cases of very large goiters or substernal goiters producing pressure symptoms, can be made more favorable risks by ligating superior thyroid arteries. In these cases the artery alone should be ligated H. H. Martin, M.D., "Goiter: Surgical Treatment" *JISMA,* November, 1914.

Treatment of Allergic Diseases with Betamethasone

SIMON S. RUBIN, M.D.
Gary

A DECADE OF clinical experience has established the value of corticosteroids in the symptomatic management of allergy. The problems associated with steroid treatment are usually those of safety rather than of efficacy: the amount and duration of dosage must be carefully selected for each patient so that symptoms are relieved with minimal risk of side reactions. My attempt to achieve this objective is described below.

Methods

Betamethasone* was administered to 89 patients, including 14 children ranging in age from 20 months to 12 years. The indication for treatment was asthma in 25 patients, allergic rhinitis in 19, contact dermatitis in 18, atopic dermatitis in 14, nasal polypi in eight and acute urticaria or angioedema in five.

The dosage level was determined by the severity of symptons and, for children, according to age and weight. Usually treatment for adults was begun with one tablet (0.6 mg.) four times daily for two days and then three times daily for two days, followed by one-half tablet (0.3 mg.) twice daily for two days. In patients with acute allergic conditions, one-half tablet daily was given for two additional days and then the drug was discontinued; in chronic or severe cases, one-half tablet daily was the usual maintenance dose.

The patients with bronchial asthma had been treated with antibiotics, aminophylline or epinephrine and other corticosteroids. They were placed on betamethasone because the previous degree of relief was considered inadequate. In severe, acute attacks, relatively high doses of betamethasone were given for brief periods until symptoms subsided. Therapy was resumed, again only briefly, if there was a recurrence. Chronic intractable asthma presented a more serious problem in that it was rarely possible to discontinue the steroid entirely; therefore, patients were maintained on the lowest dose that provided appreciable relief.

Betamethasone was used in the symptomatic treatment of patients with hay fever when they came in during the hay fever season and therefore sufficient time was not available for adequate desensitization therapy. This steroid also was used for patients with perennial allergic rhinitis with severe acute symptoms, prior to adequate desensitization therapy.

To evaluate the efficacy of betamethasone in the treatment of allergic rhinitis, an accurate daily record of the patient's symptoms was kept and daily variations in pollen counts were noted. Rubin and colleagues[1] and Feinberg[2] have shown that it is difficult to evaluate therapeutic results in the treatment of hay fever unless numerous variables are considered.

Most of the patients with atopic dermatitis had a history of chronic recurrent dermatitis including infantile eczema. Previous treatment had consisted of antihistamines, topical corticosteroids and antibiotics to combat secondary infection. Betamethasone was administered for one to three weeks. Patients with acute contact dermatitis usually required treatment for only four to seven days. In chronic allergic dermatoses, betamethasone was discontinued gradually after the major symptoms subsided. If there was a recurrence after discontinuance of the steroid, treatment with betamethasone was not usually resumed but, occasionally, the short course of therapy was repeated for especially severe acute exacerbations.

* Betamethasone (Celestone®) was provided for this study by R. Richard McCormick, M.D., of Schering Corporation, Bloomfield, New Jersey.

Results

Of the 89 patients, 59 had marked relief of symptoms and 27 reported moderate relief. Results in four patients were fair. There were no failures.

Urinalyses and determinations of blood pressure were performed frequently in all patients. Complete blood chemistries were performed in those patients who received long-term therapy. The results of all tests were within normal limits and there were no deviations during steroid treatment. There were no clinical side effects in this series.

Patients with chronic, intractable, severe asthma usually cannot be completely relieved by a steroid, except at dosage levels which are too high for prolonged administration. Low doses, which rarely produce side effects, can be given almost indefinitely to relieve disabling dyspnea and to keep the disease under reasonable control. Most of the patients with severe asthma are comfortable on one-half tablet (0.3 mg.) of betamethasone once or twice daily. This has proved to be a satisfactory means of treatment, and thus far there have been no complications.

Contact dermatitis, such as that caused by plants, is a self-limiting disease. However, brief treatment with betamethasone shortens the course; it also rapidly stops itching and therefore prevents secondary infection.

Children with atopic dermatitis frequently have a generalized dermatitis. When skin tests are necessary, betamethasone clears the skin rapidly so that these tests can be performed.

Short courses of treatment with betamethasone shrank nasal polypi completely if the polypi were not organized, thus providing relief for several months. Before treatment, the polypi had occluded the nasal passages and occasionally protruded from the nostrils. Several of my patients have had five to 15 surgical procedures to remove polypi; now surgery is rarely, if ever, necessary.

Conclusion

From my experience, and that of other investigators,[3-9] it is concluded that betamethasone is a valuable adjunct in the treatment of allergies if used properly. Although it is not curative, it provides excellent symptomatic relief. However, it should be stressed that the administration of a steroid does not substitute for long-term definitive management. Identifying the allergen, removing it from the patient's environment when possible and desensitization therapy remain the cornerstones of treatment.

Summary

Betamethasone (Celestone®) provided major symptomatic relief of respiratory and dermatologic allergies in 85 of 89 adults and children who were treated with this corticosteroid. Patients with acute conditions usually were treated for one week, during which the initial dosage of one 0.6 mg. tablet four times daily was decreased gradually to one-half tablet twice daily. When maintenance therapy was required for severe chronic conditions, one or one-half tablet daily was sufficient to keep patients comfortable. There were no clinical side effects, and the results of laboratory tests for possible toxicity remained negative in all patients.

Betamethasone therapy presents an excellent method for clearing generalized atopic dermatitis in children so that clear areas of skin become available for skin testing.

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The Rising Tide of Government Medicine

I have yet to see any desk-bound administrator or full-time politician who knows as much about the needs of a body as does the person who attends that body on an individual basis hour after hour. Concern and caution are advisable, of course, for all-drug maker, drug prescriber, drug dispenser and drug user.

But when lay judgment is substituted for professional judgment, when the sick refuse to take what is wisely prescribed, when consumer representatives and motivation hunters try to resolve medical problems without medical knowledge, when the medical profession is notified of government interventions in drug use through the popular press rather than through normal professional channels, when the public receives medical information about drug reactions before the profession is informed, the already ailing members of the public will suffer even more.

In fact, they will suffer more than any other group since it will be their own bodies which are deprived of needed medical counseling and remedies. —Austin Smith, M.D., in *Oklahoma Medical Journal* 57:8 (August), 1964.



The Case of Pragmatic Positives

ARNOLD LIEBERMAN, M.D.
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THE MEANING ACQUIRED by words can, at times, form an interesting historical commentary. Thus, few doctors today realize that the word clinic originally came from the Greek word, KLINE, meaning a couch or a bed on which people could *recline* during banquets. Patients would also lie on these same couches when examined by physicians. The modern word refers to bedside treatment or to a *clinic* where symptoms and signs are studied and treatment administered: a far cry from the couch by the banquet table but a really logical transformation.

Similarly, the word, PRAGMATIKOS, comes from the Greek term describing one skilled in law or business. Today, *pragmatism* has come to mean a *practical* or even empiric approach to any problem: the truth of the diagnosis is tested by the practical consequences of the applied treatment. When William Withering published in 1785 his famous observations on the medical application of the brew made by old wives from the leaves of the foxglove for patients dying with signs of edema and dyspnea, he confirmed the validity of the medication by the *practical* result of curing the dying; digitalis was not actually isolated from the foxglove, *Digitalis purpurea,* until much later—very much later, indeed.

Of course, when we accentuate the positive, we repeat the lines of an old song and also reaffirm the obvious.

Now, to practicing physicians the old cliche, "people are funny," is not too humorous: only wryly do we admit its truth. On that particular morning, I had just gone through the almost amazing experience of having been vituperatively excoriated by a patient with a couple of boils which appeared following a sunburn she had scratched too vigorously. She had requested "a shot of penicillin" and had become hysterically indignant when told that such therapy was not indicated in her case. She reacted as if she had been denied her birthright by a blundering idiot of a practitioner who must have obtained his medical degrees and licenses by chicanery and fraud.

The experience was so outlandish as to be almost, but not quite, funny. My face still wore a moue of distaste as I began sorting

my mail. An then I came across THE LETTER! Flooding back came many memories of a most unusual case that I had had the pleasure of attending a couple of decades ago. I had forgotten the woman's very name; the letter revived so much of what was nice: of what makes the practice of medicine, at times, so very rewarding. The obnoxious harridan who had been shrilling in my ears faded from my mind—even as I savored the resurrected past.

A Tetanic Traveler

World War II was a very recent scar; a widow of one of the war casualties had come to see me in the office. The previous evening I had been called to a motel where she had registered earlier that day. Apparently, she had blacked out while sitting in the lobby. When I saw her, some fifteen minutes later, she was still having slight convulsive twitchings even as consciousness was being regained. At first glance, they seemed the usual tonic and clonic manifestations of a grand mal seizure. The pupils were equal and regular; they reacted to light. However, there was some difficulty in seeing the fundi—was there some early cataract formation? And, rather surprisingly, the eye-grounds, when glimpsed, had a suggestion of papilledema.

As I applied the blood pressure cuff, I expected to find an elevation but the readings were normal. Then, just as I was about to release the air pressure, her hand went out in a typical carpo-pedal spasm: a very positive Trousseau sign. Surely, this could not be a part of an ordinary epileptic fit. I tapped the cheek smartly with my rubber hammer; sure enough, the complementary Chvostek sign was very positive also!

Now, albeit calcium metabolism is still one of my primary fields of interest even though my Ph.D. thesis in that area was written too many years ago, I realize that it is very poor teaching to give my diagnosis before presenting a learned discussion of the other different possibilities. Nevertheless, the order of events was just as I'm giving it.

My eyes strayed to the neck; the telltale scar of a thyroidectomy, though inconspicuous, was certainly there. I loaded a syringe with a gram of calcium gluconate. The cuff was reinflated; blood was drawn for later determinations of blood sugar, calcium and urea nitrogen; syringes were then switched and the calcium poured in via the needle still lying within the vein.

The response was rapid, satisfying and almost anticlimactically melodramatic. Even as I was still pressing firmly on the bit of cotton over the just pierced vein, the patient's tremors ceased, consciousness returned fully and she sat up with the ejaculation, "I must have blacked out again!"

I introduced myself; gave her my card and told her to see me in the morning. Now, here she was. I saw a kindly looking, quietly dressed, alert young lady. A rather pert retrousse nose went well with keen grey eyes displaying a lively intelligence. There was a minimum of rouge and ornamentation. The teeth were clean and flashed a dazzling white as she smiled and said, "Thank you very much for what you did last night; you helped me more than all the other doctors I've had so far."



It was nice to hear such a pleasant opening conversational gambit; I also had the opportunity of studying the brand new folder just started on this patient. She was 34, a widow with one son aged 15. She had worked as a confidential secretary but had been incapacitated by the epileptic seizures that had begun some two years ago and which had been increasing in both frequency and severity. Conventional therapy had been of no avail. "Brain wave" tracings had been taken repeatedly before she lost her job; experts had assured her that there were some "generalized changes but nothing suggesting a tumor or anything specific that could be operated upon." The neurologists expressed surprise at the failure of their medicaments.

The usual blood and urine tests taken that morning were mainly within normal limits. The hemoglobin, w.b.c., sedimentation rate and the usual blood sera parameters were A-OK. However, the blood calcium taken the night before was definitely below normal at 8.1 mg. %. It checked with the blood calcium taken in the morning which showed a reading of 8.6 mg. %. Also, I was surprised to see the blood sugar of the night before: a mere 58 mg. %. Not horrendously, but unquestionably low. This reading also checked with the blood sugar of the morning: 63 mg. %. Why the tendency to hypoglycemia? Did that contribute anything to her blackouts? Was there an underlying islet cell tumor? Or just a diffuse hypertrophy of the beta cells of the pancreas?

A careful office examination added nothing new. We confirmed the eye findings, found nothing unusual in the chest, abdomen or pelvis. Reflex by reflex, the neurological examination of that morning was entirely within normal limits. I thought that the new patient deserved hospitalization and a really careful and complete checkup.

Faith and Hope but no Charity

For that, however, patient consent is essential. The patient balked with a firm even if most polite, "Doctor! I've been 'worked up' time and again; I do believe you are on the right track with me just now. I do not have the money for a lot of tests and I do *not* want charity. If you can stop these attacks, I can get my job back and support my growing son. Let us give it a try." Nothing I could say would budge her.

Rather reluctantly, I explained to her that IF my hunch was correct, all she would need was a lot of sugar and calcium in her diet at frequent intervals. I suggested skimmed milk taken in generous amounts every couple of hours throughout the day. I also had the nurse get out a syringe and teach her to self-administer calcium gluconate if she felt an attack coming on. Generous helpings of sugar were also to be taken at frequent intervals.

She did come into the office for a basal metabolic rate determination which proved very low indeed. The prescribed thyroid she could afford. My fees were strictly on the P.P. (Pauper Pauperissimus) level. I had not wanted to charge her anything but her eyes flashed fire as she demanded the privilege of paying.

The diagnostic hunch was put to the *pragmatic test!* The *positives* were accentuated and—by golly—the therapy proved spectacularly effective. No more blackouts;



no more dizzy spells! I kept seeing her at decreasing intervals. The papilledema began to subside and the lens became crystal clear.

She was offered a job locally which she grabbed with avid delight. And then time came for me to leave for the East. Many years rolled by; for some years, I received Christmas cards; otherwise, contact was lost and the episode had become another dimming memory. That is, until the letter! Ah, THE LETTER! Let me quote a few extracts.

Emphasis on Empiricism

"I struggled for four years without a doctor since I did not meet one who could do so much for me as you did . . . then, I went to an internalist [sic] . . . went on tranquilizers . . . sugar shortages began to black me out again . . . I begged for calcium . . . would you write to Dr. S. and stress the sugar shortage . . . calcium deficiency

"One year I designed 20 houses and supervised their building . . . paid income taxes of $600 per month . . . remember the time I bet you 50¢ you could not hit my vein and you won?

"I appreciated how reasonable you were and your giving me the syringe. You know now I can give myself a rump shot, left-handed! . . . Now I can afford to pay the bill . . . I am offered $35,000 for my new house. So . . . bill me out. Sincerely, J.L.R.

"P.S. My boy married two days after graduation . . . has two boys . . . lovely family"

The business card of the grateful patient accompanied the letter, "Call me collect, if you wish"

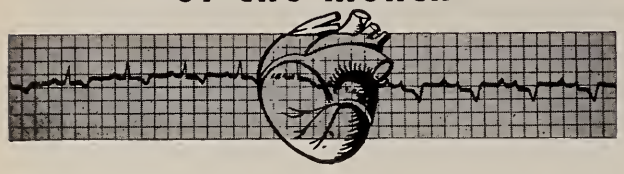
So, there we are! Actually, two completely contrasting experiences within an hour of each other. As a teaching case, this capsule is most fragmentary. We had only the couple of low readings of calcium and sugar. They *could* have been extremely low normals or even laboratory errors. The association of the hypocalcemia with the hypoglycemia is not explained on any really scientific basis.

Most obviously, however, the "widder gal" has done well on the medicaments prescribed. A bedside diagnosis was made; therapeutically, PRAGMATIC POSITIVES were accentuated: the results were most satisfactory. Even in these modern days of computer technics, a *clinical* diagnosis is still possible. Its validity may be verified by the success (or failure) of the treatment modality logically applied.

And—I must confess—that the letter: ah, THE LETTER! was good reinforcement for Old Pepys' ego just when it had been so badly jarred! Now *nothing* could bother me for the next several days. ◄

1270 Fifth Ave.
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Electrocardiogram of the month



Presented as a regular feature of The JOURNAL, Electrocardiogram of the Month is a series of short talks on cardiovascular diagnosis and treatment, edited by the staff of the Krannert Heart Research Institute, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis.

Atrial Tachycardia with A-V Alternans

CHARLES FISCH, M.D.
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AN A-V ALTERNAN can be defined as alternation of shorter and longer P-R intervals. This phenomenon is not infrequently seen during rapid heart rates and is ascribed to the existence of supernormal A-V conduction. The latter implies that the shorter R-P intervals are followed by shorter P-R intervals and longer R-P intervals are followed by longer P-R intervals. This behavior is paradoxical and opposite to the normal physiological behavior of A-V conduction.

The electrocardiogram reproduced in Figure 1 shows a paroxysmal atrial tachycardia at a rate of 190. The A-V alternan is manifested clearly by the varying R-R intervals. Following eyeball pressure, the episode of tachycardia ceased. ◄

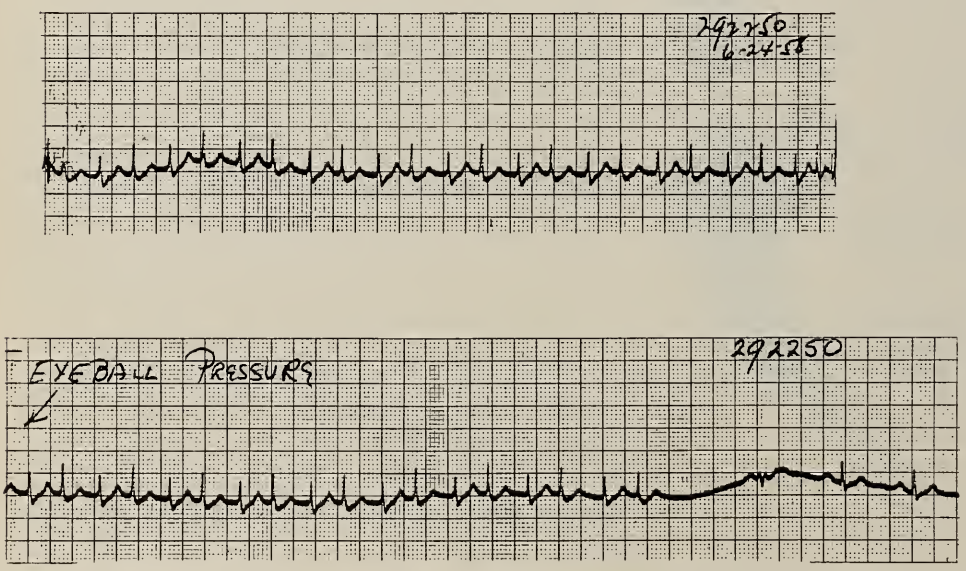


FIGURE 1
ATRIAL TACHYCARDIA with varying R-R intervals due to A-V alternans, most likely because of supernormal A-V conduction.

X-RAY CONFERENCE

Presented as a regular feature of *The Journal*, X-ray Conference is a series of short talks on procedure and radiologic diagnosis, edited by Erich K. Lang, M.D.

Traumatic Exeresis of the Brachial Plexus

C. BASIL FAUSSET, M.D.
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A 19-YEAR-OLD youth was admitted with considerable atrophy of the shoulder girdle as well as the great muscles of the right arm and forearm. The arm was entirely flaccid.

Some nine weeks prior, the patient had sustained a severe traumatic injury to his neck in a car accident. The car was traveling some 100 miles per hour and hit a stationary object. The patient was semiconscious following the crash but became aware of back pain and inability to move his right arm shortly after his admission to a hospital near the scene of the accident.

A paresis of the left leg for three days and of the right leg for approximately two weeks was observed and he complained of limitation on turning his head to the right. However, at the time of this original hospitalization, no fracture or dislocation of the cervical spine could be ascertained.

At the present admission, an electromyogram of the right trapezius, the supraspinatus, the pectoralis major, the deltoid, the triceps, the brachioradialis and the short abductor of the fifth digit, demonstrated denervation fibrillation from all areas except the trapezius and supraspinatus. There was no indication of regeneration of the affected area.

A cervical myelogram revealed remarkable findings (Figure 1). The dye puddled in a large nerve root hernia-like sac that arose from the level of C8 on the right side. The sac structure measured two and one-quarter by two and one-half centimeters. The position was considerably more lateral and over a larger extent than one would expect with a nerve root sleeve hernia. The appearance was that of a dural traumatic exeresis with formation of an arachnoid cyst projecting beyond the confines of the intervertebral foramen.

Pantopaque dye was injected into one of the large nerves of the right forearm.



FIGURE 1
A CERVICAL myelogram demonstrates dye pooled in a large nerve root hernia sac at C8 right. Also, defective filling is seen at the C5, 6 and 7 levels on the right.

Serial films were obtained over the next 96 hours to observe retrograde perineurolymphatic transport of the contrast medium and to ascertain the exact site of severance of the nerve roots. At the end of this period, dye was seen in the distal end of the peripheral nerve in the supra-clavicular fossa, representing the avulsed distal end of the nerve (Figure 2).

An exploratory operation showed C5 and C6 nerve roots to be densely and deeply scarred in their foramina; C7 and C8 nerve roots were completely absent. An arachnoid cyst which had formed at D1 contained no nerve tissue.

Discussion

Cervical myelograms are extremely useful in the diagnosis of traumatic nerve root hernias or traumatic exeresis of the nerve roots with formation of dural or arachnoid pseudocysts. At times, the filiform ends of the torn nerve roots may actually be seen in the contrast medium filled cystic structures.

For accurate localization of the point of severance of a peripheral nerve, injection into the perineural tissue with a contrast medium is recommended. Retrograde perineurolymphatic transport will gradually move the contrast medium to the cord. The point of interruption is demonstrated by failure of further transport of the dye.

Particular care should be taken not to confuse a severed nerve end with a Ranvier's membrane of the perineural sheath, which will also simulate interruption of the dye transport. However, delayed films, made 24 hours later, will show a continuance of the transport of contrast medium beyond the Ranvier's membrane.

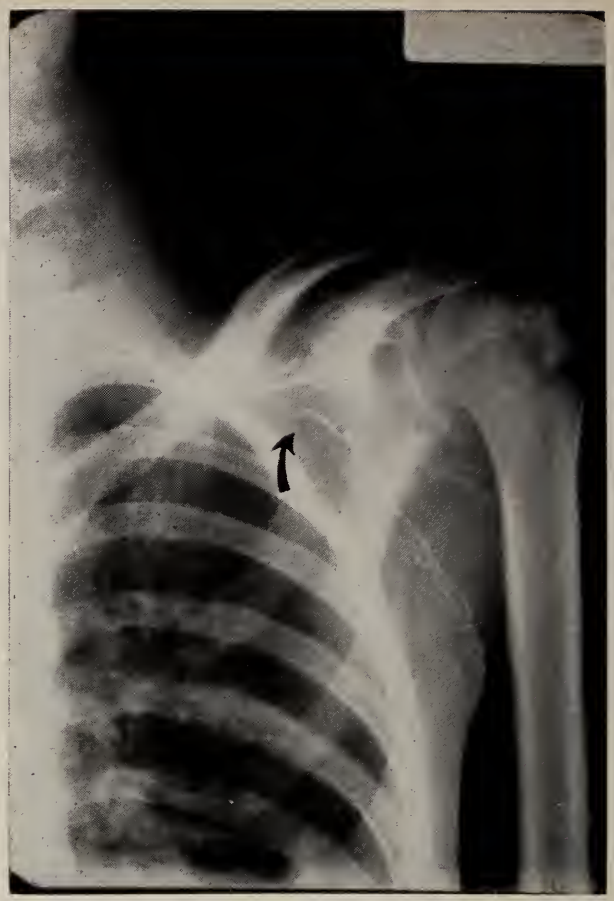


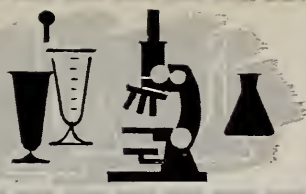
FIGURE 2

NINETY-SIX hours after injection of pantopaque into a right forearm nerve, retrograde perineurolymphatic circulation has transported the dye to the avulsed distal end of the peripheral nerve in the supra-clavicular fossa.

Cervical myelography, as well as injection of perineurolymphatic spaces, is an innocuous procedure without significant morbidity. It is extremely worthwhile in the evaluation of a patient for reconstructive surgery after a traumatic injury of the motor roots or peripheral nerves. ◄

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Path-finder
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Pulmonary Function Tests (Part III)

WEI-PING LOH, M.D.*
Gary

A. Equipment for pulmonary function testing:

The instruments listed in Table 1 are easy to use and are sufficiently accurate for clinical purposes.[11]

B. Steps in initial evaluation:

1. Analysis of *history.*
2. Careful *physical examination.*
3. Review of *chest x-rays*—current films, previous films and inspiration-expiration pairs.
4. *Function studies*—
 Routine: maximal voluntary ventilation, vital capacity, timed vital capacity, (all repeated after inhalation of Isuprel, if indicated), RBC, hematocrit.
 In selected cases: walking ventilation; spirogram—for frequency, tidal volume, minute volume, calculation of alveolar ventilation, FEF and inspiratory flow rates, etc.; electrocardiogram, circulation times.
5. Fluoroscopy.

Steps 1, 2 and 3 give important clues to the nature and degree of alterations of pulmonary function. The information obtained from the function studies can then be interpreted and applied intelligently on the basis of pulmonary physiology. The initial evaluation should provide sufficient information for the management of most patients with pulmonary disease. The patient may be referred to the cardiopulmonary laboratory of a medical center for additional studies, if necessary.

C. Case illustration:

The following examples (from Comroe, et al., *The Lungs*) serve as a guide to interpretation of the initial studies and to recommendations for further investigation:

Example 1—All initial tests normal.
No symptoms and no clinical or radiologic evidence of cardiopulmonary disease.
Patient is almost certainly normal.

Example 2—All initial tests normal.
Patient complains of "blueness."
Suspect pulmonary or cardiac venous-to-arterial shunt or abnormal (inactive) hemoglobin.
Further studies: arterial oxygen after inhalation of 100% 0_2; cardiac catheterization; angiocardiography; spectrophotometric analysis for abnormal hemoglobin.

Example 3—All initial tests normal.
Patient complains of shortness of breath.
Suspect neurocirculatory asthenia; pulmonary vascular disorder (embolism, vascular sclerosis, pulmonary hypertension or left heart failure).
Further studies: complete

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INSTRUMENT	USED FOR	AVAILABLE FROM	APPROXIMATE COST
1 Ventube (portable)	MVV Exercise ventilation	J. H. Emerson Co. 22 Cottage Park Ave. Cambridge 40, Mass.	$ 85.00
2. Vitalor (portable)	Vital capacity Timed vital capacity FEF	McKesson Appliance Co. Toledo 10, Ohio	$165.00
or Timed Vitalometer	Vital capacity Timed vital capacity	Warren E. Collins, Inc. 555 Huntington Ave. Boston 15, Mass.	$225.00
or Respirometer	Spirogram, including Frequency Lung volumes (except RV) Vital capacity Timed vital capacity FEF and MIFR Minute volume Calculation of alveolar vent	Warren E. Collins Co.	$550.00 (9 L)
3. Wright peak flow meter	Peak expiratory flow[12]	J. J. Monaghan Co. 500 Alcott St. Denver 4, Colorado	$180.00

Table 1

pulmonary function studies of ventilation, distribution, diffusion and arterial blood; alveolar-arterial $p0_2$ difference; cardiac catheterization.

Example 4—Initial tests normal except for decrease in alveolar ventilation.

Suspect central lesion near medullary respiratory centers.

Further studies: test the respiratory center by observing ventilatory response to inhalation of 5-10% CO_2 in air.

Example 5—MVV—decreased; FVC—normal, or nearly so; FEV and FEF—decreased.

Suspect pattern of obstruction (due to asthma, bronchostenosis, bronchitis or emphysema).

Repeat the initial tests after bronchodilator (? of reversible bronchospasm).

Further studies: for objective or analytical data do —distribution of inspired air; residual volume; total lung capacity; volume of trapped gas; airway resistance and pulmonary compliance.

Example 6—MVV—normal; FVC—decreased; FEV and FEF—normal, or nearly so; alveolar ventilation—normal, or increased.

Suspect pattern of restriction or impaired diffusion; look for cyanosis and radiologic evidence of diffuse infiltration.

Further studies: arterial blood gas studies at rest, exercise and while breathing 0_2; diffusing capacity; compliance and tissue resistance.

Example 7—MVV—decreased; FVC—decreased; FEV and FEF—decreased; alveolar ventilation—normal.

Suspect: pattern of ob-

struction; restriction; pulmonary vascular congestion; neurological disorder. Repeat the screening tests after bronchodilator or after treatment for congestive heart failure.

Further studies: Complete pulmonary function studies.

Example 8—MVV—decreased; FVC—decreased; FEV and FEF—decreased; alveolar ventilation—decreased.

Suspect hypoventilation due to neurologic, neuromuscular or muscular disorder; severe obstruction or restriction.

Further studies: Complete pulmonary function studies.

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Editor's Note

This concludes Dr. Loh's paper on Pulmonary Function Tests. Due to its length, the paper has been published in three parts. Part 1 appeared on pp. 973-974 of the September issue and Part 2 on pp. 1150-1153 of the October issue. ◄

Life Sciences vs. Deadly Diseases

With all the progress that has been made, much remains to be done. Medical research is still almost impotent against multiple sclerosis, cystic fibrosis, mongolism, muscular dystrophy and many other conditions.

Fortunately, medical progress is being carried forward by contributions of basic knowledge by men and women in the life sciences. Indeed, all the life and social sciences are now being brought to bear on the control of disease and its consequences.

There is every reason for confidence that the enemies of mankind's health will be overcome one by one in the future through the combined efforts of the entire medical team. The pharmaceutical industry anticipates with pride the part that it will play in the ultimate success.—Alfred E. Driscoll, President, Warner-Lambert Pharmaceutical Company, in *New England Journal of Medicine* 270:6 (Feb. 6, 1964).

LABORATORY MEDICINE

This page reviews established or relatively new but reliable laboratory procedures for physicians in general. It is not designed for specialists and laboratory personnel who would desire more technical information.

Serologic Tests for Syphilis (Part 1)

WEI-PING LOH, M.D.*
Gary

SINCE AUGUST VON WASSERMAN first described his complement fixation test for syphilis in 1906, many other standard tests for syphilis (STS) have been introduced for clinical use. They all are based on the same biologic phenomenon: the demonstration of a biologically nonspecific antibody, "reagin," in serum by its reaction with a lipoidal or cardiolipin antigen from normal beef heart.[1,2] In an effort to find more specific tests, the use of Treponema pallidum organisms as the specific antigen was introduced in the late 1940's.[3]

In order to avoid the technical difficulties and high expense of the Treponema pallidum tests, D'Alessandro described a purified protein extract from Reiter treponemes in 1953 which apparently contains an antigen in common with the virulent Treponema pallidum.[4] In 1957, Deacon and coworkers first described the fluorescent Treponemal antibody test.[5]

It now appears that multiple antigens and antibodies are involved in syphilitic infection and each test is detecting a different antibody. These antibodies may differ in quantity at any given stage of the disease and this explains the difference in testing results when multiple tests are employed at the same time.

Constant attempts have been made to develop a test which offers absolute sensitivity and specificity in establishing or ruling out a diagnosis of syphilis. As yet, no single test has achieved this ideal goal. When test sensitivity is increased beyond certain limits, there is a resultant loss of specificity and vice versa.[6] No single test is best for all conditions disregarding stage of the disease, treatment and other factors involved. No single test is free from false reactions. Test results should always be correlated with history and clinical findings.

There have been changes in the reporting system concerning qualitative STS. Upon recommendation of the National Advisory Serology Council, the test results are no longer reported as negative or positive, one plus through four plus. Instead, the test results are now reported in terms of "non-reactive," "weakly reactive" and "reactive."[7]

Serologic Tests and Their Characteristics

There are more than 50 serologic tests for syphilis but many of them are now obsolete. More recently, the following tests have been in common use.

Nontreponemal Tests

VDRL (Venereal Disease Research Lab.)
Mazzini
Kahn
Kline
Kolmer
Kolmer (one-fifth volume)
Hinton
RPR (rapid plasma reagin)

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USR (unheated serum reagin)
PCT (plasmacrit)
RPR Card Test
APHA Microfloc.
Micro. Precipitation
Rein-Bossak
(Kolmer tests are complement fixation tests. Others are flocculation or precipitation tests).

Treponema Pallidum Tests

TPI (Treponema pallidum immobilization)
TPI-200 (using 200 u. complement)
TPA (Treponema pallidum agglutination)
TPIA (Treponema pallidum immune adherence)
TPMB (Treponema pallidum methylene blue)
TPCF (Treponema pallidum complement fixation)
FTA (Fluorescent treponemal antibody)
FTA 1-5 (using 1:5 dilution)
FTA-200 (using 1:200 dilution)
FTA-ABS (FTA absorption technic)

Reiter Treponeme Tests

RPCF (Reiter protein complement fixation)
KRP (Kolmer Reiter protein)
KRP (one-fifth volume)

1. The standard serologic tests for syphilis using nontreponemal antigens seem unchallenged as the most effective device in screening for syphilis.[8] All commonly used flocculation tests, such as Mazzini, VDRL, Kline and Kahn are equally effective, if they are properly performed and properly controlled.
2. RPR, USR and RPR card tests seem to be more reactive than the VDRL slide test.[9,10] The Microhematocrit-PCT test is useful in blood banks for rapid screening of blood donors.[10] In evaluation of individual patients, standard serologic tests using nontreponemal antigens are always preferred to these rapid tests.
3. Since 1949, approximately three dozen tests in the treponemal antigen category have been described. Today, only three tests in this overall group continue to cause much interest—the TPI, the Reiter protein tests (KRP, RPCF) and the FTA tests.[11] The other treponemal tests were found to be inferior and a few of them presented technical difficulties.
4. A satisfactory treponemal test offers at least two major uses: differentiation between latent syphilis and biologic false-positive reactions (BFP) and a sensitivity greater than nontreponemal tests in syphilis of many years' duration.[11]
5. The technically demanding and expensive TPI test is properly performed today in only ten laboratories in this country. It is relatively insensitive in early syphilis but has great sensitivity in syphilis of many years' duration, especially after treatment (as long as eight years after completion of penicillin therapy). TPI is generally more specific than STS. The TPI test is often used as a basis of reference for the validity of other tests.
6. Reiter protein tests are relatively inexpensive and the KRP test has received the widest application to date. KRP is generally more specific than STS.[2] In comparison with TPI, KRP is more reactive in early syphilis and less reactive in syphilis of many years' duration.[2,11] Thus the KRP and TPI can supplement each other under those conditions. RPCF test appears to be less valuable.[10]
7. The FTA tests have been found to be promising. The initial FTA 1-5 test appears to be too sensitive and there is lack of specificity. The modified FTA-200 test is highly specific, although seriously lacking in sensitivity.
8. The newest FTA-ABS test appears to be most promising. In initial evaluations, the FTA-ABS test is comparable to TPI test in specificity and gives a greater sensitivity than any recommended treponemal and nontreponemal test.[11,12]

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(To be continued).

Goof Balls — Physicians and Pharmacists

The *American Journal of Psychiatry* 120:750, 1964, carried an interesting report concerning so-called goof balls which are described as a "green heart (a tablet containing dextroamphetamine and amobarbital) and a red bullet (a capsule containing secobarbital)." The article quoted statements by a "goof ball addict" which should give us cause for reflection and seems to refute some recent pronouncements by FDA. The addict states:

> "You know, give me $200, my good clothes and 12 hours of freedom. If I come back, I could bring you enough red bullets and green hearts to keep me high for six months. Does this show how clever I am? No, it shows how naive or indifferent doctors are."

Almost any doctor, according to this addict, will pass out a prescription for secobarbital. Another will write a prescription for the green heart component of the goof ball. Some physicians, especially psychiatrists, are "mean" enough to put a non-repeat symbol on the prescription. "So you go to a general practitioner." It is surprising, however, how easy it is to talk a doctor into authorizing a new supply. Retail pharmacists, according to this goof ball addict, are more suspicious than physicians. She would have trouble, she said, if she tried to buy her supply week after week from the same drug store. Fortunately, she explained, there are pharmacies on almost every corner.

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Medical Research Growth a Problem

THE TREMENDOUS GROWTH of medical research threatens to decimate the supply of researchers and to paralyze the means of recording and making available the results.

In five years industrial medical research has increased by 50% to $300 million annually. Federal expenditures have trebled to $1 billion. Teaching and philanthropic institutions have increased their funds by 50% to $150 million.

The Pharmaceutical Manufacturers Association issued a statement of policy recently in which four major problems are outlined:

1. Federal government medical research has increased to the point that it is difficult to administer efficiently.
2. Research is being diverted from that which produces basic knowledge to projects intended to provide immediate results.
3. Teachers are being lured into research; there may not be enough teachers to educate scientists of the future.
4. Federal patent policies provide inadequate incentive to cooperation between industry and non-industry scientists.

The PMA believes that public and private philanthropic funds are best suited for expenditure in basic research, with programs free of restrictive planning and control. The pharmaceutical industry is especially well suited for the application of basic knowledge and the discovery of new drugs.

Government support should not compete with private investigation, but should be available if private resources are found to be inadequate in terms of national needs.

There is a trend for government intrusion into areas of research previously supported by private funds. Many advances in medicine have been financed by both public and private sources. If recognition and freedom are not accorded contributors of private funds, the size of the government grant program may stifle the incentive to research by industry, universities and foundations.

Government policies in regard to patent rights in discoveries resulting from research partially or indirectly subsidized by government funds have a tendency to worsen the situation.

The PMA also believes that all government and philanthropic research activities should provide education and training for young scientists. Otherwise the exclusive use of scientists as researchers but not as

part-time teachers will stunt the crop of future researchers.

Dissemination of new knowledge and also of negative results will speed the adoption of practical research and lessen the number of investigations repeated because negative results have not been announced.

Conclusions of the PMA statement:

1. There should be adequate exchange of information and proper administration of the research activities supported by the federal government to keep to a minimum undesirable duplication of research, eliminate unnecessary research projects and prevent waste of scientifically trained manpower.

2. There should be improved scientific communication of the results of medical research supported by the government. All grantees and contractors should be required to submit regular, detailed, and meaningful reports which should be made available to the scientific community unless national security is involved or confidentiality must be maintained.

3. There should be a realistic government patent policy, which would apply equally to patents in the medical and other fields. Such a policy should be planned and developed to encourage cooperation between industry, other privately supported researchers and government-supported scientists.

4. Government funds should be principally allocated to encourage basic research that could expand fundamental knowledge in all medical fields. They should not normally be used to underwrite applied research and development, which is primarily the responsibility of the private sector of the nation's economy.

5. Since further progress in medicine depends upon the supply of properly trained scientists, additional teachers and research personnel are needed and they should have adequate financial support and encouragement.

6. There is need for a broadly based national council at the highest levels of the federal government to help formulate and guide policy in government-supported medical research. The council should consist of citizens representing interested and qualified groups in this field.

Surgeon General's Annual Report

THE ANNUAL REPORT of the Surgeon General of the U. S. Army for the fiscal year 1963 has just been published. Certain highlights dominate the report as follows:

1. The health of the Army is the best it has ever been. The major morbidity indexes reached a record low level.

2. Highly trained specialists head the clinical services. The number of cardiologists and thoracic surgeons especially expanded last year. Over 70% of the physicians on duty in orthopedic and general surgery are board qualified or board certified. Most of these are trained in Army residency programs.

3. The dependents' medical care program continues to be a great morale factor throughout the Armed Forces. Last year there was a five percent increase in the program for hospital care and a slight decrease in fees paid to physicians.

4. An Army-wide tuberculosis control program and improvements in the immunization program, as well as increased attention to respiratory diseases, influenza, infectious hepatitis and malaria have contributed markedly to lower morbidity rates.

5. In addition to approved residency programs in clinical specialties, approval has now been granted for four years of training in anatomic pathology and clinical pathology, as well as a forensic pathology program at the Armed Forces Institute of Pathology.

6. The Army continues to train medical officers in the special problems of aviation, because of the increasing number of aircraft operated by the Army.

7. More and more hospitals are being converted to mechanized accounting. Seven installations went to punchcard reporting last year.

8. The Army now has 43 hospitals in the United States and 23 hospitals overseas which are fully accredited by the

joint commission.

General Heaton says in his foreword: "In looking to the future of the Army Medical Service, suffice it to say that it can never be disassociated from the future of the Medical Corps. The physician is, and always will be, the central figure in the practice of medicine. The quality of patient care provided in the Army hinges primarily on the knowledge, skill and devotion of our physicians."

World's First Electronic Librarian

MEDICAL LITERATURE has become so massive as to make great segments of it inaccessible to ordinary screening and review mechanisms. The actual bulk of data, especially that of medical research, prevents a scholar from finding and utilizing important information and still have time for new research.

The National Library of Medicine is developing an electronic system to catalog the many thousands of medical articles appearing each year and to make it possible, quickly, to find any classification of information desired.

This year the National Library will be indexing more than 16,000 issues of medical journals with an average of 10 articles each. By 1970 it is expected that 25,000 issues containing 250,000 articles will be received annually. This is in addition to books and monographs.

The mediator of the gigantic task of indexing and making available all items of this mountain of literature is a large-scale Honeywell 800 computer. The system is known as the Medical Literature Analysis and Retrieval System (MEDLARS).

The computer stores all pertinent information for each article on magnetic tape indexed in such a manner that a request for information on any particular subject will immediately call out of the files everything that has been recorded on the subject.

One reel of magnetic tape will contain information on from 25,000 to 30,000 medical articles. The computer is able to search one reel in five minutes. The medical literature for a five-year period can be searched in two and one-half hours. The time involved in accomplishing this by conventional methods would be astronomical.

One of the major products of the system is the Index Medicus which contains approximately 12,000 bibliographies in each month's issue. The computer works on this stint for only three hours per month. The tape which is produced for Index Medicus is fed into another wonder machine, an optical printer, which converts the computer's output into photocopy from which the printing plates are made. The optical printer reproduces complete pages at the rate of 300 characters per second.

MEDLARS will also be used to prepare specialized medical bibliographies and research bibliographies which require special treatment not available in the Index Medicus and other standard works.

The "electronic librarian" will greatly simplify the task of handling the mass of data required because of the spilling over of one branch of science into several others. Molecular biology and bioengineering are each derived from a dozen or so different disciplines. Medical research in the future must be woven into the intricacies of physical science which is also developing at a tremendous rate. If it were not for the computers, there would be no practical method for storing and retrieving the data that will be produced.

Physicians on the Move

AMERICAN PHYSICIANS are constantly changing in numbers, in specialization and in the location of their work.

During the past 20 to 30 years, shifts in these categories have been gradual, but for the most part have all been in the same direction and have produced major changes in the profession. Health Information Foundation outlines these changes in its latest bulletin.

The only variation of recent times concerns the ratio of all physicians to total population. From 1940 to 1960, the ratio was remarkably constant and remained

close to 136 per 100,000 during the 20 years. Since 1960, the ratio has risen and is now 145.8 per 100,000. A part of this ratio increase is due, however, to a change in the method of classification.

Since 1931 there have been three increases which have been most marked. These involve increases in the percentages of full-time specialists, physicians in training and physicians with the federal government services.*

The above increases have produced a decrease in the percentage of part-time specialists and general practitioners and also a decrease of the number of physicians in private practice. The loss of physicians in private practice is partially compensated for by the fact that the greatly increased resident staffs and the increased federal government physicians, especially with the VA, are actually busy with patient care in conjunction with or instead of private practitioners.

In this connection, if interns and residents are included in the count of all physicians whose main activity is to provide direct services to patients, the percentage of physicians so engaged has declined from 98% of all active non-federal physicians to only 92% in the 33-year period.

Actually, the ratio of physicians in private practice to civilian resident population declined a relatively small amount, from 108.4 per 100,000 in 1931 to 93 per 100,000 in 1964.

The trend toward group practice is also significant. Groups of three or more physicians practicing together accounted for an increase of physicians so engaged to a total number of 11,443 in 1959. This is a 228% increase over 1946 figures.

An interesting, though unexplained, phenomenon is that full-time specialists in group practice are board certified (75%) to a much greater extent than specialists as a whole (45%).

Interns and residents have increased in absolute numbers almost seven times, but there are still 18% of the internships unfilled and 13% of the residencies. Vacancies would be more numerous if it were not for foreign physicians who constituted 25% of the total in 1960.

As the profession changes in its character, composition and mode of practice, its training is becoming more highly organized and more time consuming, it is specializing more and more and at the same time it is remaining essentially in private practice.

* Full-time specialists in private practice are up by 381%. Interns and residents have increased by 576%. Doctors on full-time duty with the federal government are up by 517%.

Guest Editorials

The Use of Drugs and the Doctor-Patient Relationship

AS PHYSICIANS, and thus, practitioners of the healing art, it behooves us to approach our daily therapeutic patient contacts with great humility as well as adequate self- and professional-knowledge.

The degree of confidence bestowed upon us by our patients, simply because we represent a traditionally respected profession, not only provides the background for marvelous and often unexpected, nonspecific therapeutic effects, but also amplifies and extends the effectiveness of potent therapeutic agents and manipulative activities.

The positive "placebo" effect is now well recognized by any informed physician. It demonstrates, beyond question, that whatever the good, well-informed and truly concerned physician may do which the patient can interpret as *treatment* usually has an ameliorative or even curative effect. Such power must be respected, never exploited, never overplayed nor overextended, for if we betray the patient's solid confidence in so doing, there must come a reckoning, and with that, a tragic reduction in the therapeutic powers not only of the offending physician, but of his many uninvolved and, as yet, unidentified professional colleagues.

The positive "placebo" effect must be continuously created by the physician. It is created by him through his responsible behavior in coming to know his patients competently, intimately and sufficiently in depth. Its essential vehicles are the ade-

quate history and inventory, the careful physical examination, the studied and economic laboratory investigation, and the final sharing, in simplicity and honesty, of his resulting knowledge *and ignorance* with his patient. These are the vehicles which underwrite and sustain durable confidence.

If the physician, in his professional behavior, proves that he is worthy of confidence, his patient will demonstrate that confidence wherever placebo as well as specific effects are possible. On the other hand, we press our powers inordinately when we presume to treat immediately or prematurely before we have acquired any solid knowledge of the patient, or before, in fact, he has come to put his confidence in us. Under such circumstances, we may well expect that the patient will either demonstrate negative "placebo" effects (which are, by no means, uncommon) to our therapy, or will, in effect, refuse to follow our simple leads.

The observations which Dr. Lynn has reviewed in his paper "Psychopharmacologic Survey of Psychiatric Referrals," appearing on pp. 1229-35 of this journal, should give all of us pause for sober thought and reappraisal. I am confident that his discovery that only 43% of his referred patients, who were given specific instructions by their physicians, actually followed these instructions (took medications as prescribed) must not be dismissed as a needlessly harsh judgment affecting only "thee" but not "me."

All of us have been victims of professional pressures, crowded waiting lists or waiting rooms, conflicting responsibilities, distraction and lack of concern, on innumerable occasions in our professional lives. These data simply remind us that the patient attends, that the patient can sense our concern or lack of it, that the patient tends to develop his attitudes toward us and what we are trying to do from what we actually do in the interview and examining room.

Dr. Lynn's statistics remind us, most eloquently, that the patient's confidence must be gained and earned by our own work, if we are to proceed under the justified conviction that our counsels are being effectively followed, not in half or less of our patients, but, ideally, in all of them.—**John I. Nurnberger, M.D., Professor and Chairman, The Department of Psychiatry and Acting Dean, Indiana University School of Medicine, Indianapolis.**

Statewide Diabetes Detection

AS DIABETES DETECTION WEEK (November 15 to 21) draws nearer, an increasing emphasis on diabetes and the importance of early diagnosis should become manifest in the public mind as well as in the medical society's and physician's offices throughout the country. The organization of diabetes detection programs by medical groups, either as affiliates of the American Diabetes Association or as county medical societies, can and should provide a rewarding experience for all concerned.

The experience of the Indianapolis Diabetes Association reveals that a significant number of unknown diabetics can be found over the short space of one week as a result of organized mass screening through the help of leaders in business, industry, service clubs and civic groups. The 1963 detection campaign in Marion County alone detected at least 116 proven cases of unsuspected diabetes out of a total of 541 urine positive suspects. Statistics from the American Diabetes Association show that in 1964 there will be almost twice as many known diabetics in the United States as there were in 1950, because of the increasing frequency of the disease and improved detection methods.

Of particular importance in the Marion County detection campaign has been the magnificent support given by the retail druggists in distributing Dreypaks (free diabetes test kits) in each and every pharmacy during detection week. The Indianapolis Diabetes Association commends the Indiana Pharmaceutical Association for their growing interest in cooperating with county societies throughout Indiana in organizing annual diabetes detection campaigns in all major areas of the state.

Information about the organization of a

diabetes detection campaign in your area may be obtained by contacting the Indianapolis Diabetes Association, 821 Hume Mansur Bldg., Indianapolis 4, telephone Me 9-1111, or by writing the American Diabetes Association Inc., 1 East 45th St., New York 17. A cooperative program between your medical society and the pharmacists in your area will meet the challenge of the rising incidence of diabetes and contribute significantly to the health of your community.—**Richard J. McAlpine, M.D., Chairman, Diabetes Detection Drive, Indianapolis Diabetes Association.**

Editorial Notes...

Adolescents have four major health problems—being overweight, auto accidents, emotional problems and venereal disease. Overweight children are in trouble because they almost always grow up to be overweight adults. The age of adolescence is usually one of good health, and of low mortality, yet half of the deaths from age 10 to age 20 are accidental, mainly from auto accidents. One-third of all patients receiving out-patient treatment for emotional disorders are adolescents. Venereal disease incidence is rising, much of it occurring in adolescents. For these reasons Dr. Felix P. Heald, Jr., of Washington, D. C. is urging special attention for this age group.

The Pharmaceutical Manufacturers Association and 41 individual companies have filed suit against the Food and Drug Administration contesting regulations promulgated by FDA under the 1962 amendments. The regulations objected to would require detailed and repetitive reports on all drugs marketed since 1938 the same as though each "old" drug was a "new" drug. The industry claims that the requirements of the amended law apply to "new drugs" (those for which a new drug application is in effect) and not to drugs which have been authenticated by the test of time. In fact the law defines new drugs in such a way as to exclude drugs which have been used often enough and long enough to be considered safe and effective. The legal definition also excludes drugs marketed prior to the passage of the "drug" amendments. The basic objection to the regulations is that the intricate record keeping and reporting required will increase the price of all drugs. Drug prices have been declining steadily for several years; this is *no* time to unnecessarily raise them.

The Army's new portable medical unit, the "Medical Unit Self-Contained Transportable (MUST)" has successfully passed weather tests of temperatures from 65 below zero to 140 above, high humidity conditions, winds up to 80 miles per hour and up to four inches of rain per hour. The shelter units are inflatable and vary in size from small up to a hospital ward accommodating 20 patients. Each shelter may be deflated, compacted and packed in a shipping container along with other equipment needed for full function. The surgery shelter and all its equipment can be carried on a standard 2½-ton truck, by air or by rail.

Ten thousand and four hundred new M.D.'s each year have been recommended as a goal for the year 1975. This means that 11,700 first year students should be admitted in 1971. This is nearly 3,000 more than are admitted now, but some progress is being made. New four-year schools at the University of Arizona, University of California at San Diego, University of Connecticut, Hershey Medical Center, University of Massachusetts, Mount Sinai Hospital and University of Texas and two-year schools at Brown University, University of Hawaii, Michigan State University, University of New Mexico and Rutgers, when completed will provide a little over 800 new first year places. Two thousand and two hundred new first year places are still needed. The Association of American Medical Colleges thinks most of these new places must be created by the expansion of existing schools.

Facilities for psychiatric patients should be built into general hospitals. This is a tendency which has been manifested in recent years in both private and governmental hospitals. The VA is building a new general

hospital of 710 beds in Washington, D.C. It will have provisions for 240 psychiatric patients in eight 30-bed nursing units. Each unit will have four single rooms, one two-bed room and six rooms with four beds. To encourage a small group, family-living atmosphere, each unit will have its own solarium, sitting room and dining room.

Disposable hospital supplies, it seems, are here to stay. One hundred and twenty-five million dollars worth were used last year, probably $300 million or more by 1970. Experience so far has shown that they are practical and economical. The American Hospital Association is studying ways to improve the disposables and wants to establish methods of evaluating future products prior to hospital use. The AHA is also working with hospital architects to eliminate from construction those conventional features which will not be needed in the future because of disposable supplies. The biggest item for investigation however, is how to dispose of the disposables. Some items, such as hypo needles, are dangerous if not discarded properly.

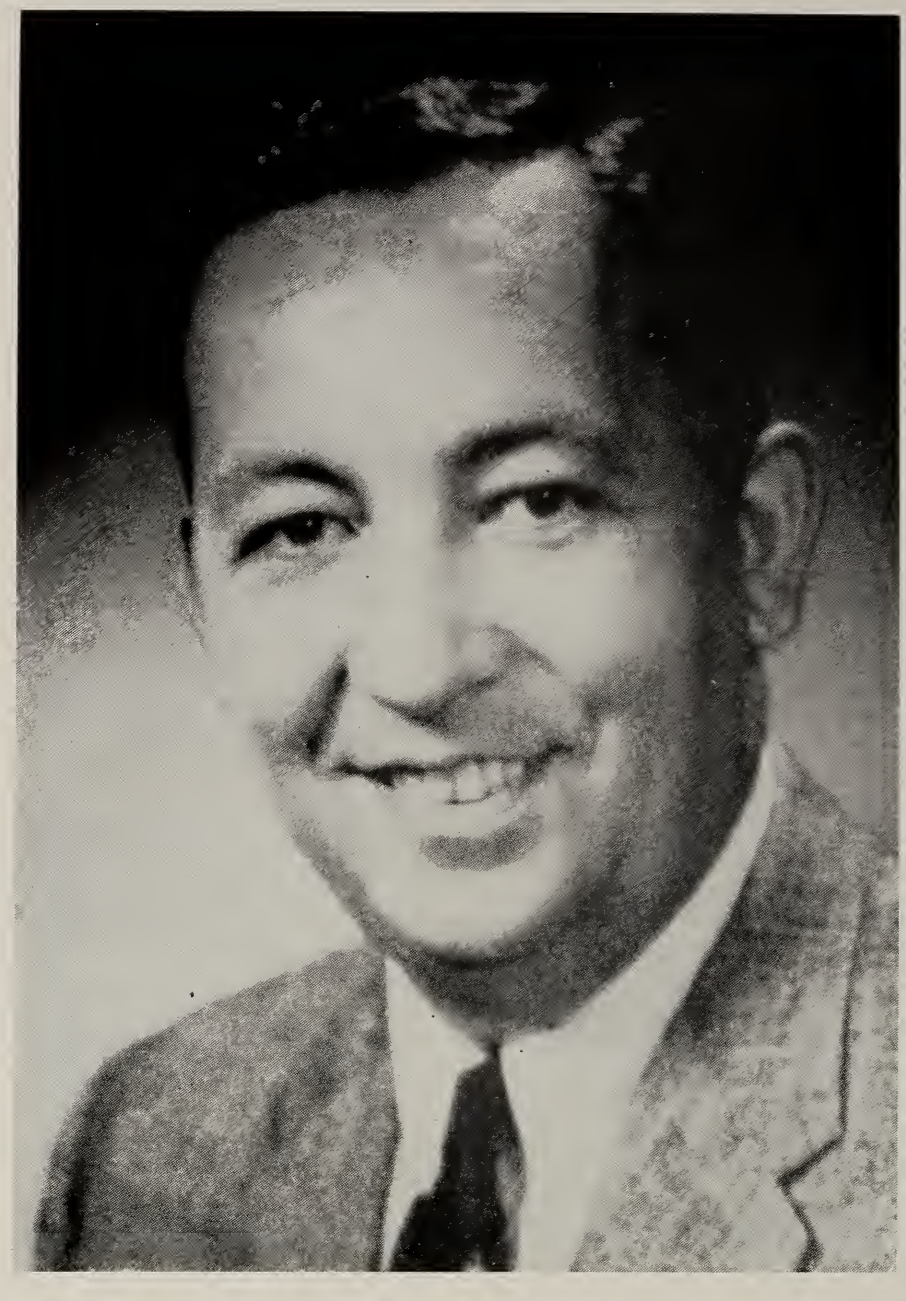
New strains of the influenza virus are being encountered and recognized in various parts of the world as we go from one epidemic to another. The U. S. Army Medical Service is altering the composition of its influenzal vaccine by discontinuing the use of two of the older strains and adding two new strains—one isolated in a recent outbreak in Maryland and the other from Japan.

"Registered" blood for transfusion is now a possibility. The Avery Label Company has produced a set of seven adhesive backed labels, each carrying the same serial identification number, for attachment to the patient's tab-band, to the patient's chart, to the tube containing the patient's blood and to up to four units of blood which are determined to be compatable. Any unit of blood given the patient thereafter should have the same serial number as that appearing on the patient's tab-band. This is one more device, of which we cannot have too many, to insure the administration of proper blood.

One reason, and incidentally the main one, that hospital construction is so expensive is that modern hospitals are the most complicated buildings built. The mechanical and electrical systems in hospitals contribute a large and steadily increasing percentage of the building cost. The Basic Construction Company of Richmond, Virginia has completed 74 hospitals and has four in progress. Its president points out that hospital heating systems must provide for individual room temperatures and that air conditioning systems differ from ordinary buildings in that they must bring in fresh air and not recirculate contaminants. Vacuum systems require a separate system of pipes and pumps. Piped in oxygen and piping for anesthetic gases, as well as vacuum pipes for transporting messages and small items, all add to the maze of piping seldom seen in other buildings. Electrical installations are similarly complicated. The modern advances in medical care add to the cost but add more to the efficacy of medical treatment.

The prescription drug industry has just concluded a three-year investigation to define standards for plastics which are used to make containers for injectable drugs. Requirements for glass containers for the same purpose have been published by the USP for 25 years. The USP and National Formulary will now study the research findings and decide whether the standards for plastics should be adopted and published.

Accidental death among men of working age is too high now and continues to get higher. In the age bracket from 15 to 64, the Metropolitan Life Insurance Company reports, 45,000 men died of accidental injuries in 1963 compared with 42,600 in 1962. The rate per 100,000 rose from 79 to 82. Only about a fifth of the deaths occurred at work or as a result of work. Many industries are organizing safety campaigns for the time the men are away from the factory. Of all the age brackets, the one from 20 to 24 has the highest death rate, due chiefly to the high rate of motor vehicle deaths in this age group. ◄



JOE M. BLACK, M.D.

President

Indiana State Medical Association

1964-65

Dr. Joseph M. Black began his term as president of the Indiana State Medical Association on October 15 when he accepted the gavel and the challenge of the presidency from Dr. Donald E. Wood in the Murat Temple.

"Dr. Joe," as he is affectionately called by his friends and patients, is a family practitioner from Seymour where he was born and reared.

Dr. Black graduated from Indiana University in 1941 with a degree in chemistry and was in many campus activities including Sigma Alpha Epsilon social fraternity, Blue Key, Sphinx Club, freshman athletics and the I. Men's Association. He was graduated from Indiana University School of Medicine in December 1944, and had his internship and residency at Marion County General Hospital. He spent two years in the service in various Army hospitals.

In 1942, Dr. Joe married his high school sweetheart, Mary Annette Elsner. Mary has been active in the medical auxiliary and is a past state president. Mary and Joe have three children, Deborah, 17, Susan, 16 and Joe Jr., 13.

Dr. Black has been active in the affairs of the association having served as president of his local society, district councilor, president-elect of the ISMA and several terms as co-chairman of the Legislative Commission. He has been active in the Indiana Academy of General Practice serving as a director and chairman of their Legislative and Public Relations Committee and is a member of the National Academy Commission on Legislation and Public Relations. He has been a member of the Blue Shield Board for several years and has served on its Professional Relations Committee. He helped in organizing I-HOPE and has been its treasurer.

Believing that physicians should be active in their community, Dr. Joe has served as president of his Rotary Club, on the board of directors of the Chamber of Commerce, the Seymour Country Club, Cancer Society and the Methodist Church. He holds memberships in many social and fraternal groups.

Next to his family and his profession, he has a keen interest in Indiana University, his alma mater and is presently serving as vice-president of the I.U. Alumni Association and is a member of the screening committee to help select a new dean of the I.U. Medical School.

Athletics being a hobby, Dr. Joe holds membership in the Hoosier Hundred and the I.U. Varsity Club. His wife, Mary, has always maintained an active interest in his profession and their community. She is a past-president of her medical auxiliary, Tri Kappa sorority, on the Girls' Club Board, a Girl Scout leader for seven years, is a co-chairman of the Seymour United Fund and is on the Seymour Public Library board. She has held a state office in Tri Kappa for the past four years.

Dr. Black believes that the Indiana State Medical Association is the common ground for all physicians in Indiana. He feels that the image of the Indiana physician is enhanced by being active in his profession and in his community. His experiences in these efforts should make him a competent leader for our association. He lives by the slogan, "A job worth doing, and friends worth having, make life worth living."

The Woman's Auxiliary

REPORTS TO ISMA

Doctors' wives traveled many miles to attend the Area Workshops which were held in Wabash, Indianapolis, and French Lick. These meetings were arranged and conducted by the vice-presidents of the Northern, Central and Southern Areas; namely, Mrs. R. J. Morrical of Logansport, Mrs. John W. Deever of Indianapolis and Mrs. Alfred B. Scales of Huntingburg. State officers attended and excellent, fast-moving programs were presented by our state committee chairmen. Thirty-six of our 60 county auxiliaries were represented.



Coffee and rolls were served at 9:30 a.m. before the meetings began, there was a luncheon each noon and the meetings lasted until 2:30 p.m. Officers and chairmen participating in the presentation of these Area Workshop programs were: Mrs. H. Carter Dunstone, Mrs. John M. Sullivan, Mrs. Kenneth D. Schneider, Mrs. Jack E. Shields, Mrs. Thomas W. Johnson, Mrs. J. Winford Mather, Mrs. Donald R. Taylor, Mrs. Stephen D. Smith, Mrs. Dwight W. Schuster, Mrs. Paul Sparks, Mrs. Robert M. Seibel, Mrs. Albert L. Marshall, Mrs. Milton V. Caldwell, Mrs. Richard Glenn Horswell, Mrs. Francis Gootee, Mrs. E. R. Jacobs, Mrs. John G. Suelzer and Mrs. Herbert L. Sedam.

Our state legislative chairman, Mrs. Dwight W. Schuster, is appointing a committee of 15 members to alert the 60 county auxiliaries when immediate action is indicated. Efforts of the legislative committee are also being directed toward the presentation of a two-day public speaking seminar and the "precinct action course." The hope is that through such efforts, each auxiliary member will be more conscious of her responsibilities and opportunities in the field of legislation.

As we approach Thanksgiving Day, we can be grateful for many blessings, one of which is our American heritage. We are working together for good, hoping that that for which we give thanks can be enjoyed by generations yet to come.

Bea Shields

PEPTIC ULCER • FUNCTIONAL HYPERMOTILITY • IRRITABLE COLON

PYLOROSPASM • BILIARY DYSKINESIA • PANCREATITIS • URETERAL AND URINARY BLADDER SPASM • GASTRITIS



PRO-BANTHINE (propantheline bromide) Assures Authoritative Anticholinergic Control in Gastrointestinal Dysfunctions

The clear and consistent therapeutic benefits of Pro-Banthine (propantheline bromide) have made it the preferred anticholinergic for the past decade.

During that time, many compounds have been developed and proposed as alternatives. In the appraisal of Roach[1] "... few, if any, have seemed to offer a distinct improvement, ..."

Early investigations showed that Pro-Banthine (propantheline bromide) reduces motility and acid secretion and may be used in a wide range of dosage, to bring prompt, positive anticholinergic benefits to patients with peptic ulcer, spastic colon, pylorospasm and related gastrointestinal dysfunctions.

Recent evaluations sustain these earlier judgments. In a current authoritative assessment based mainly on the factors of potency, superiority to atropine, clinical experience and physiologic study, Steinberg and Almy[2] select as the first two preferred anticholinergic drugs, methantheline [Banthine] and propantheline [Pro-Banthine].

The name Pro-Banthine (propantheline bromide) sets a stamp of therapeutic authority on any anticholinergic prescription.

Side Effects and Precautions—Urinary hesitancy, xerostomia, mydriasis and, theoretically, a curare-like action may occur. The drug is contraindicated in patients with glaucoma or severe cardiac disease.

Dosage—The usual adult dosage is one tablet of 15 mg. with meals and two at bedtime; this amount may be doubled or tripled for patients with severe conditions. Pro-Banthine (brand of propantheline bromide) is supplied as tablets of 15 mg. and, for parenteral use, as serum-type ampuls of 30 mg.

SEARLE

Chicago, Illinois 60680

Research in the Service of Medicine

1. Roach, T. C.: Therapy of Peptic Ulcer, J. Louisiana Med. Soc. *115*:136-139 (April) 1963.
2. Steinberg, H., and Almy, T. P., Drugs for Gastrointestinal Disturbances, Chapter 21, in Modell, W. (editor): Drugs of Choice —1964-1965, St. Louis, The C. V. Mosby Company, 1964, p. 343.

PYLOROSPASM • BILIARY DYSKINESIA • PANCREATITIS • URETERAL AND URINARY BLADDER SPASM • GASTRITIS

PEPTIC ULCER • FUNCTIONAL HYPERMOTILITY • IRRITABLE COLON

Doctor Diplomats

More News from the Congo

MY THREE MONTHS in the Congo in the summer of 1963 were spent at Bibanga Mission, located in south-central Congo in the newly created province of South Kasai. It is about 400 miles south of the equator at an elevation of about 3,000 feet.

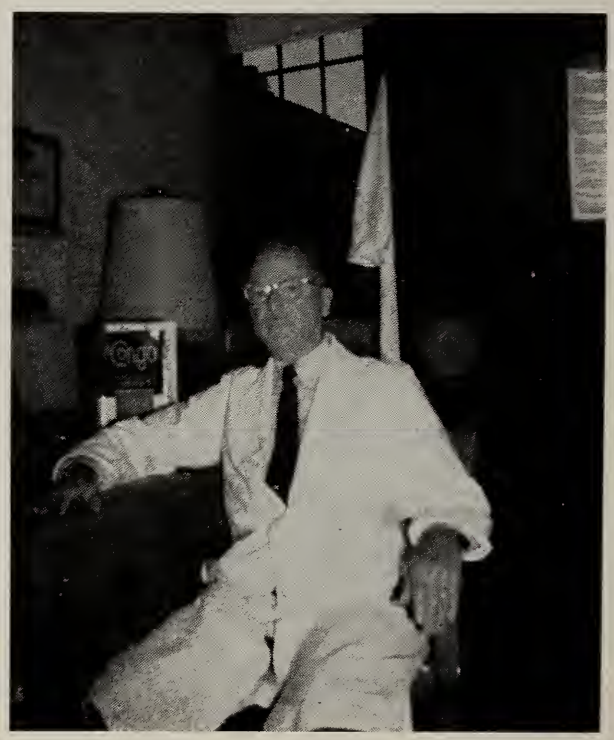
The mission homes line the rim of a promontory that juts over a beautiful, wide valley. On clear days one can see 50 miles across the rolling grassland. While, theoretically, it was the winter season during my stay, the temperature did not vary more than five degrees from the summer season. The dry season runs from May to September; however during my "summer" stay there were four rains. While the grassland becomes dry and brown—the season for burning off the land prior to cultivation—flowers bloomed, trees were green and fruit ripened. The humidity was low and the shade temperature was in the high 80's. A good breeze blew most of the time and, all in all, it was delightful weather.

Wonderful native fruit is abundant and fresh beef is available at all times from a slaughter house about 20 miles away. There have been no dairy cattle in this area since independence was granted, so powdered milk is used exclusively by the mission homes and the hospital. Each home is furnished with a kerosene-operated refrigerator. Meat is frozen until needed, ice cubes for tea and fruit drinks are always available and frozen salads and desserts and ice cream are a part of the daily menu.

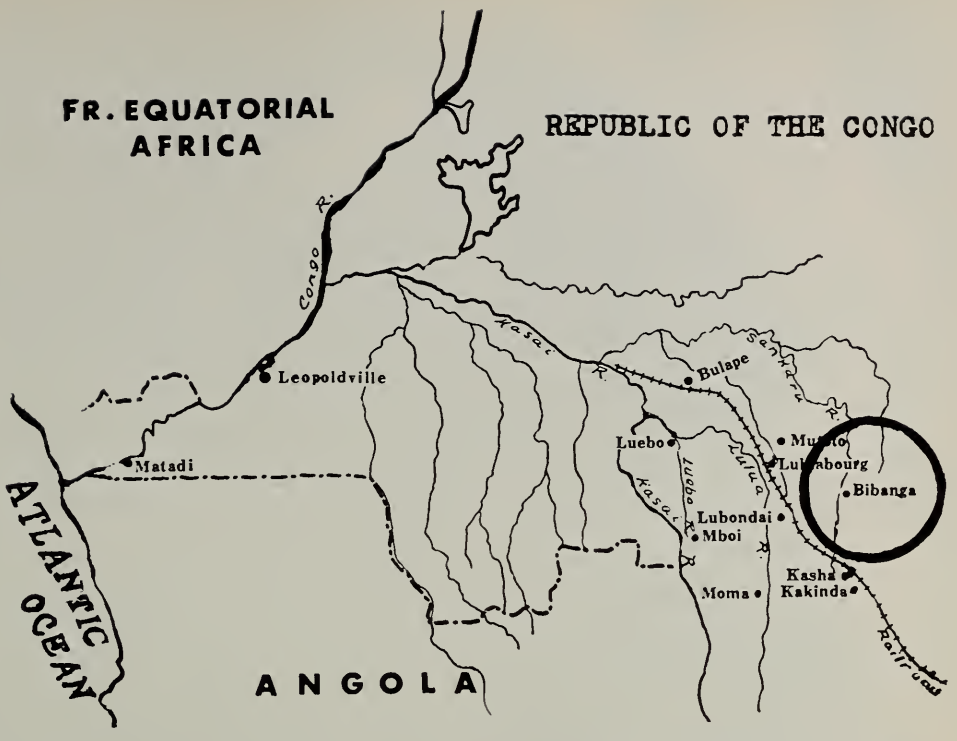
My living quarters were in a large guest house with six beds in four bedrooms. Meals were taken in daily rotation with the other eight homes on the mission. Electricity is provided 24-hours-a-day from a small hydroelectric plant located about five miles away. Water is piped in from a large spring at the foot of the hill to a standpipe and the baths are equipped with hot and cold running water. Drinking water is always boiled.

The Baluba tribe traditionally occupy the South Kasai and Northern Katanga region. One of the larger tribes of the Congo, numbering about one and one-third million people, they are among the best educated and most enterprising. Before their independence, they provided a large segment of the skilled manpower of the copper industry of Katanga and the industrial diamond mines of the South Kasai . . . these mines furnish about 90% of the world's supply of industrial diamonds.

Historically, the Baluba's have been compared with the Hebrews of the Old Testament, for three reasons: because they were more domesticated and peaceable, they were held in bondage for years by their neighbors; they were widely dispersed (even



William C. Reed, M.D.
Bloomington
BOOK in background is "Congo — Background of Conflict" by Alan P. Merriam, a professor at Indiana University.



CIRCLE INDICATES location of Bibanga Mission, South Kasai Province, Republic of the Congo.

though retaining their homeland, thousands went to Leopoldville and many thousands more went to Elizabethville and Northern Katanga as well as to smaller cities throughout the Congo); and finally, they were smart enough to make themselves indispensible to those in high places in government and industry—in many instances ending up as second in command.

The Baluba's are a friendly people with a real desire for education. They are appreciative of the help they receive from the mission, the United Nations and the United States. Now that their nation has been given its freedom, they realize how poorly prepared they are to administer their potentially important and rich country.

Sex and Superstition

Many patients come to the hospital with evidence of having been to the native medicine man (he is not referred to as a witch doctor). During my stay, one boy was admitted with recently healed, radiating scars about his left nipple; he had complained of "pain in his heart." Many wear a small charm around their neck in the form of a sack containing hair, a piece of a fingernail and possibly a piece of skin from some animal.

Girls marry young—12 or 13 years of age—but not before they have had one menstrual period and are "ready for marriage," meaning that they are ready to become pregnant and so start the cycle of annual childbearing which will continue throughout their reproductive years. The husband "buys his wife," making a present to the girl's father which may amount to as much as $40 to $50 in U.S. money. For each child born to the couple, the father-in-law receives an additional gift, either money or some article of value. For this reason, female babies are looked upon with favor.

A peculiar belief of the natives is that twins are considered an omen of bad luck and that both of them cannot be reared. If the twins are male and female, they will permit the male twin to die from exposure or starvation.

Their number one interest in life is sex. A large family is a "status symbol" in the Congo. A sterile wife is sure to be turned out by her husband . . . there are no divorce laws. Sterility problems account for most of the domestic trouble and occupy a large portion of the mission doctor's time.

Polygamy is the accepted custom and a man may have as many wives as he can afford. Loss of manhood is a matter of grave concern to the male population, which also takes a great deal of the doctor's time. This loss of manhood is a relative term; a man may complain if he can have inter-

course but three times a week instead of three times a night as formerly. If a man has two or more wives and does not take care of them to their satisfaction, they will gang up on him and refuse to cook for him!

Facts and Facilities

The hospital was founded in 1917 by Dr. Kellersberger, a German-speaking Swiss missionary. He gained an international reputation in tropical medicine for his pioneer work on Hansen's disease and trypanosomiasis. The hospital comprises eight one-story buildings. The concrete and masonry administration building was constructed about 10 years ago; this houses doctors and nurses offices, pharmacy, x-ray, the admissions office and a large classroom. The other buildings were all constructed in the early '20's and are made of native brick. All the buildings have corrugated iron roofs.

There are pediatric, men's and women's wards and a laboratory building. The tuberculosis ward and the dispensary occupy opposite ends of the same building. The obstetrical ward has a delivery room at one end. The obstetrical equipment is old and meager. All normal deliveries are handled by Congolese practical nurses, young men and women trained in the hospital for three years. The mission doctor is called only in cases which are not progressing normally or in cases where there is the possibility of or necessity for cesarean section.

The surgical building contains a large operating room with windows on two sides. There is a small exhaust fan high on one wall which helps to circulate the air. The equipment, although old, is in good working order. The operating table is adjustable as is the overhead lamp, giving a fair amount of illumination—and unwanted heat. The only time I perspired all summer was under this light—especially when performing a difficult procedure with two Congolese practical nurses as assistants. In addition to the overhead lamp, there is also a portable lamp.

The instruments were in good repair and adequate for the type of surgery performed; I found a good supply of Bard-Parker blades. Gloves, however, were somewhat of a problem. I found only four pairs of my size, 6½, available; these were soon gone and I used size 7 for the remainder of my stay. This proved somewhat of a handicap.

Sutures of all sizes and materials were in stock but the linen supply was quite limited, permitting us to operate only three days a week. Sterilization was by live steam from a wood fired boiler in the building.

Spinal anesthesia is employed about 90% of the time. I would give the spinal, then operate while the mission R. N. observed the blood pressure. Local and regional anesthetics are also used and, very occasionally, the nurse will give open drop ether to a child. The hospital has no gas machine.

Many Different Diseases

Diseases in the Congo often differ markedly from those found here at home. For instance appendicitis is quite rare as are gall stones and kidney stones. Ulcers of the stomach and duodenum are seldom seen and gastric cancers are infrequent. Cancer of the breast is quite a rarity. This surprised me, as the nipple is used as a pacifier at all times. Carcinoma of the skin too is rare, in spite of the constant exposure of large areas of skin to the rays of the equatorial sun.

Diabetes, hypertension and varicose veins are all uncommon. I was told that prostatic hypertrophy was practically unheard of—perhaps the corollary to this is the fact that the natives live a very active sex life right up to the last gasp. Hydroceles are common and usually allowed to become quite large. Inguinal herniae are four times as frequent as here at home—this could be explained by the fact that so many infants suffer from the protein deficiency disease, kwashiorkor, which is characterized by an enormous distension of the abdomen.

Goiters are very frequently seen and are unusually large; those I saw were all nontoxic but some were huge nodules. This area is in a "goiter belt" and all the mission homes use iodized salt.

Fibroid tumors of the uterus are frequent and large, and carcinoma of the uterus, cervix and vulva are common. Anemias are frequently found and tend to be severe.

Continued



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in moderate to moderately severe pain...

Each scored yellow PERCODAN* Tablet contains 4.50 mg. oxycodone hydrochloride (Warning: May be habit-forming), 0.38 mg. oxycodone terephthalate (Warning: May be habit-forming), 0.38 mg. homatropine terephthalate, 224 mg. aspirin, 160 mg. phenacetin, and 32 mg. caffeine.

Throughout the wide middle range of pain PERCODAN assures speed, duration, and depth of analgesia by the oral route plus the reliability that counts so much. PERCODAN acts within 5 to 15 minutes...usually provides *uninterrupted* relief for 6 hours or longer with just 1 tablet...rarely causes constipation.

Average Adult Dose—1 tablet every 6 hours. **Precautions, Side Effects and Contraindications**—The habit-forming potentialities of PERCODAN are somewhat less than those of morphine and somewhat greater than those of codeine. The usual precautions should be observed as with other opiate analgesics. Although generally well tolerated, PERCODAN may cause nausea, emesis, or constipation in some patients. PERCODAN should be used with caution in patients with known idiosyncrasies to aspirin or phenacetin, and in those with blood dyscrasias. **Also Available:** PERCODAN®-DEMI, each scored pink tablet containing 2.25 mg. oxycodone hydrochloride (Warning: May be habit-forming), 0.19 mg. oxycodone terephthalate (Warning: May be habit-forming), 0.19 mg. homatropine terephthalate, 224 mg. aspirin, 160 mg. phenacetin, and 32 mg. caffeine. *U. S. Pats. 2,628,185 and 2,907,768

Literature on request.

ENDO LABORATORIES INC., Garden City, New York

Endo®

Many infants suffering from kwashiorkor were admitted with two Gm. hemoglobin. Other problems are malaria and intestinal parasites.

Malaria is the number one disease of the Congo, responsible for an infant mortality rate of 50-60% and is the cause of many miscarriages. Intestinal parasites account for 25% of all out-patient consultations; the mortality from this is usually slight except for diarrhea in infants. Hookworm is widespread. Infestation with flukes (schistosomiasis) causes a liver condition similar to cirrhosis with ascites. One young man was admitted with this infestation and had an enormous distension of the abdomen—10 liters of ascitic fluid were aspirated the following day! These parasites also inhabit the bladder resulting in severe and chronic cystitis. Carcinoma of the bladder is 10 times more frequent in the Congo than it is in the U. S. One huge echinococcus cyst of the liver was operated upon during my stay.

Kwashiorkor, referred to earlier, is due to early weaning to a diet composed entirely of carbohydrates. This food is made of ground corn (maize) and powered manioc root which grows to a large size, similar to a potato. This mixture is cooked in a pot with a little water, over an open fire, until it reaches the consistency of thick mush. Everyone eats large quantities of this twice a day. Infants from about three months old have this food poked down their throats by their mother's finger.

The most obvious symptom of kwashiorkor is the huge distension of the abdomen and the marked edema of the face and lower extremities. Mental apathy (a characteristically dour expression), muscular atrophy, severe diarrhea and severe anemia complete the picture. A peculiar finding is the depigmentation and straightening of their normally black kinky hair. The almost miraculous cure of this condition is simple: powdered milk and iron in some form. If they do not die immediately from diarrhea induced by this diet, they will recover. Many of these cases are also given blood transfusions.

Respiratory diseases, mainly tuberculosis and pneumonia, represent 15% of all hospital admissions and account for 25% of all deaths.

The practice of 10 or 12 people sleeping in a small mud hut with the door closed and a smudge fire to repel the mosquitoes, aggravates the susceptibility to tuberculosis. Bone and gland tuberculosis is also seen very frequently.

Gonorrheal infections in patients of both sexes are both common and freely admitted. Pelvic inflammatory disease, resulting from gonorrheal infection, accounts of course for a good percentage of pelvic surgery. Syphilis is uncommon, no other forms of venereal disease were encountered by me.

"Miseries Cut Out"

The Congolese believe that surgery will cure anything and many come to the out-patient clinic asking to have their "miseries cut out." Operations performed during my sojourn at the hospital included:

Varicose veins, bilateral, severe. Multiple ligations, local anesthetic. (The only case of this kind admitted to the hospital for years.)

Appendectomy, interval. (First instance for many years.)

Excision of right submandibular gland, draining sinus, local anesthetic.

Cesarean section, two cases (one repeat and one dystocia.)

Hydrocele (numerous) usually large and bilateral.

Thyroidectomy for large adenomatous goiters (Many in men and women 18-20 years of age.)

Echinococcus cyst of liver, huge. Excision and packing cavity loosely with gauze.

Inguinal hernia* (numerous and usually large.)

Hysterectomy, abdominal, for fibroid tumors.

Hysterectomy, vaginal, for severe prolapse.

Osteomyelitis, right mandible, curett-

* Many Congolese had umbilical herniae but not one patient wanted the umbilical hernia repaired. The iguinal hernia, however, was getting close to their external genitalia and was, therefore, of great concern to them.

ment.

Excision of perineal fistula, Foley catheter anchored.

Myxosarcoma, large, overlying sacral region. Excision.

Pelvic laparotomies (Many for salpingectomy and salpingo-oophorectomy.)

Miscellaneous: extraction of homemade lead bullet from joint cavity of right knee; D & C (mostly in connection with Rubin test); excision of huge keloid scar; hydrocele of cord (in surgery a small, perfectly formed third testes was found on the left side.) A few lipomas, sebaceous cysts and paracentesis abdominalis.

In all, about 80 major operations were performed during my service.

The postoperative course of Congolese patients is unique. Morphine, either preoperative or postoperative is not used; 75-100 mgs. Demerol is sufficient—the patients expect to suffer and they do not complain. To my knowledge, no patient is ever catheterized, no enema is given and no laxatives are used. About the second day after surgery, they get out of bed, go to "the grass" and one hears no more about it.

They eat whatever their family provides, for, as in other regions of the Congo, patients are accompanied by the family who remain as long as the patient is hospitalized. They live in huts provided by the hospital and cook food for themselves and for their hospitalized relative in an iron pot over an open fire.

The normal capacity of the hospital is 75 beds, but just as here as at home, there are times when there are twice that number. However, their method of expansion is more simple. A straw mat is placed on the floor between each bed. Surprising is the fact that many patients prefer to sleep on the floor for they are unused to soft beds.

Prenatal Clinics and Prescriptions

In addition to operating three days a week, there is an out-patient clinic each afternoon except Saturday and a prenatal clinic each Friday morning. There are 75 to 85 patients at the latter clinic every week. The natives are encouraged to come into the hospital for delivery and the cost is just pennies in our money.

Some of the case histories at the prenatal clinic are startling. One child, seen by me, was 15 years old, and in her third pregnancy! When I asked her why she had been married shortly after her 12th birthday she answered, "Because I had already had one period, my breasts were developed and I was ready to get married." Another woman, in her mid-20's was pregnant for the eighth time, but had never carried a pregnancy to term. There was another woman, also in her mid-20's who had delivered eight full-term babies and had no living child.

Patients receiving prescriptions at the out-patient clinic take them to the dispensary to be filled. However, as I soon learned, they are given only one dose at a time, and return daily or several times daily as directed to receive their medicine. If they are given a two-weeks supply they would probably take it all within a day or two, or would take it back to their village and sell it, returning to the dispensary for more stating that they have lost it.

This necessary dispensary practice, plus the families of the in-patients, results in a huge crowd of people milling about the hospital grounds at all times.

There is a leper camp located about five miles from the hospital. It houses 120 elderly patients. Modern treatment does not require isolation or institutional care but these Hansen's disease patients have been there so long that they have no other homes to go to. The dispensary at the leprosarium gives them sulfones supplemented by streptomycin and dihydrostreptomycin. Anemia, a frequently associated finding, is treated with iron and liver concentrate.

A Dedicated Staff

The mission doctor, a splendid young man in his mid-30's, was born in China to missionary parents, educated in the United States and is a graduate of the Medical College of Virginia. The mission nurse was born to missionary parents at Bibanga, grew up in the Congo and speaks the Chuluba dialect like a native. At 18 years of age, she made her first visit to the United States and was graduated from Emery University School of Nursing in Atlanta and also took some special training in anes-

thesia. She is an utterly dedicated person, devoting her life to nursing in the Congo.

The x-ray and laboratory technician is a young lady who is also an able teacher, having trained several laboratory technicians who are now able to type and cross-match blood, do routine blood counts, malaria smears, stool examinations for parasites and sperm counts.

The Congolese graduate nurse is a married man in his early 40's with 10 children and is a splendid Christian gentleman. Having received excellent training under very competent doctors for eight years, he is capable of doing skin grafts, excising cysts and lipomas, reducing simple fractures and administering blood or fluids intravenously—he could hit a vein that I could scarcely feel! Furthermore, he has the respect and admiration of all the patients. He can do more for them than either the doctor or nurse when making rounds, listening to each patient's complaint and giving them encouragement and advice.

My two Congolese assistants in surgery were boys who had graduated from the school for practical nursing at the mission. One boy was slow, methodical and thorough —I was told that he once gave mouth-to-mouth resuscitation to a newborn for 45 minutes and finally got the baby breathing on its own. My other boy was alert, intelligent and quick to learn the suture routine.

The wards are staffed by four young men and four young women, all graduates of the aforementioned school of practical nursing. Some of these nurses are excellent, keeping the welfare of the patients uppermost in their minds and also keeping good records. Other perhaps are not quite so suited to their work. All hospital records and doctors' orders are written in French. The temperature charts are printed in centigrades—37 deg. C. being normal.

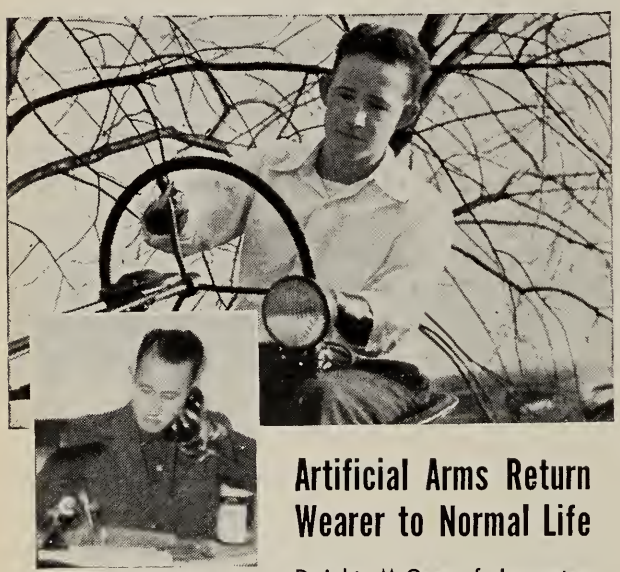
The pharmacist, who has been a longtime resident, and the administrator, who is a minor chief in his home village, make up the remainder of the permanent staff.

In addition to the hospital and nursing school, the mission also conducts an excellent educational program. They run a primary school with an enrollment of over 300 and a secondary school almost as large. English is taught from the first grade through secondary school. All instruction in the secondary school is given in French. There is also a training school for preachers where young men who have finished secondary school are given preliminary training for the ministry. The more promising of these students are now being sent to colleges in the United States to complete their training.

We *must* help to train thousands of doctors, nurses, ministers, teachers, lawyers and administrators so that they, in turn, can go back to their villages and assume their responsibilities. For the hope of the Congo is to train their *own* people to take care of *themselves.*

Just as the graduate nurse, mentioned earlier, could do more to reassure the patients than either the mission doctor or nurse, so will these newly-trained leaders be able to do more for their own people than has been done for them by others in the past. ◄

William C. Reed, M.D.
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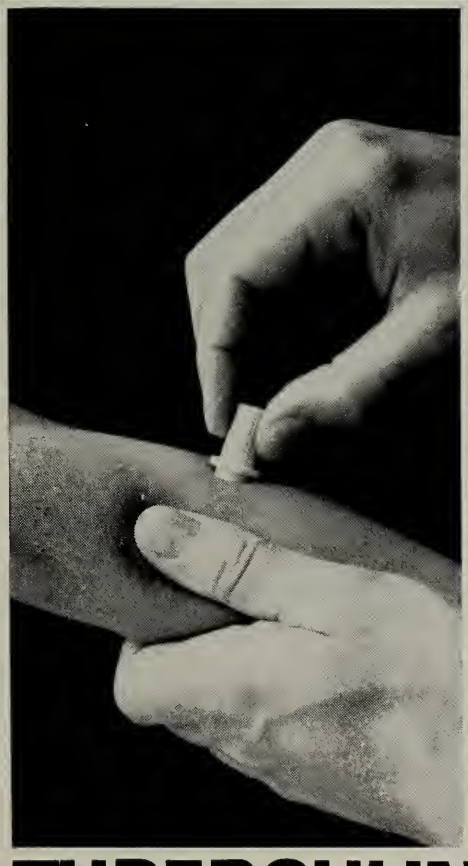
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Interpreted by
ROBERT HOLLOWELL, LL.B., legal counsel
Indianapo'is

Q. Can a physician be subpoenaed to attend trial in counties other than his own county and adjoining counties?

A. Prior to a 1963 amendment, the courts held that a witness could not be subpoenaed to appear in court as a witness other than in his own county and adjoining counties. However, there was no statute so expressly providing. This was by virtue of a court decision which construed together a number of sections of the Witness Statute and the Deposition Statute, including the section that only allowed a witness mileage to the limit of the adjoining county and that a deposition could be taken where a witness lives more than one county removed from the county in which the action was pending. In *Alexander et al.* v. *Harrison*, 2 Ind, App. 47, the court said at page 50:

> "It would often result in a great hardship to compel a citizen to go as a witness to any county in the State for the small compensation provided by the statute, and to avoid the infliction of this hardship the Legislature has provided ample means for securing the testimony of witnesses living in distant counties, by deposition. Construing the several provisions of the statute upon this subject, as a whole, we think it clear that the attendance of a witness can not be enforced except in the county in which he lives or is served with process, or in an adjoining county."

In 1963, the legislature amended the section of the statute which fixed witness fees and the mileage of witnesses. They increased the witness fees and the mileage fees and deleted the provision which limited the mileage to the border of the adjoining county. This is Sec. 2-1710, Burns' Ind. Statutes.

Some attorneys are now taking the position that because the courts' decisions are based, in part, upon the fact that witnesses could not be paid beyond the limit of the adjoining county, that the removal of this restriction by the 1963 amendment now permits a witness to be subpoenaed to attend court any place in the state. However, at the same session House Bill #1059 was introduced to amend Sec. 2-1707 by language which would expressly permit witnesses to be subpoenaed to attend any place in the state. This bill did not pass.

Since the courts' decisions are not predicated solely upon a provision limiting the payment of mileage to the limits of an adjoining county, I do not believe that this amendment alone will permit the subpoenaing of witnesses to attend any place in the state. However, it may take a court decision to settle this question.

My conclusion is influenced by the fact that the legislature expressly refused to pass a bill which would specifically accomplish that purpose, so it was apparently not the intention of the legislature to permit that result.

In addition, I also call your attention to Sec. 2-1722, Burns' 1946 Repl. (Ph. pt.), which is as follows:

> "*Experts.*—A witness who is an expert in any art, science, trade, profession or mystery may be compelled to appear and testify in any court in the county of the residence of the witness or any court in the adjoining county to an opinion, as such expert, in relation to any matter, whatever such opinion is material evidence relevant to an issue on trial before a court or

jury, without payment or tender of compensation other than the per diem and mileage allowed by law to witnesses, under the same rules and regulations by which he can be compelled to appear and testify to his knowledge of facts relevant to the same issue. (Acts 1881 (Spec. Sess.), ch. 38, §282, p. 240; 1959, ch. 138, §1, p. 343.)" ◄

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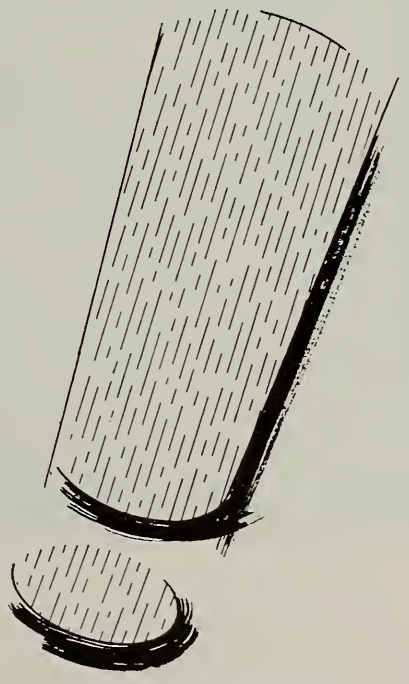
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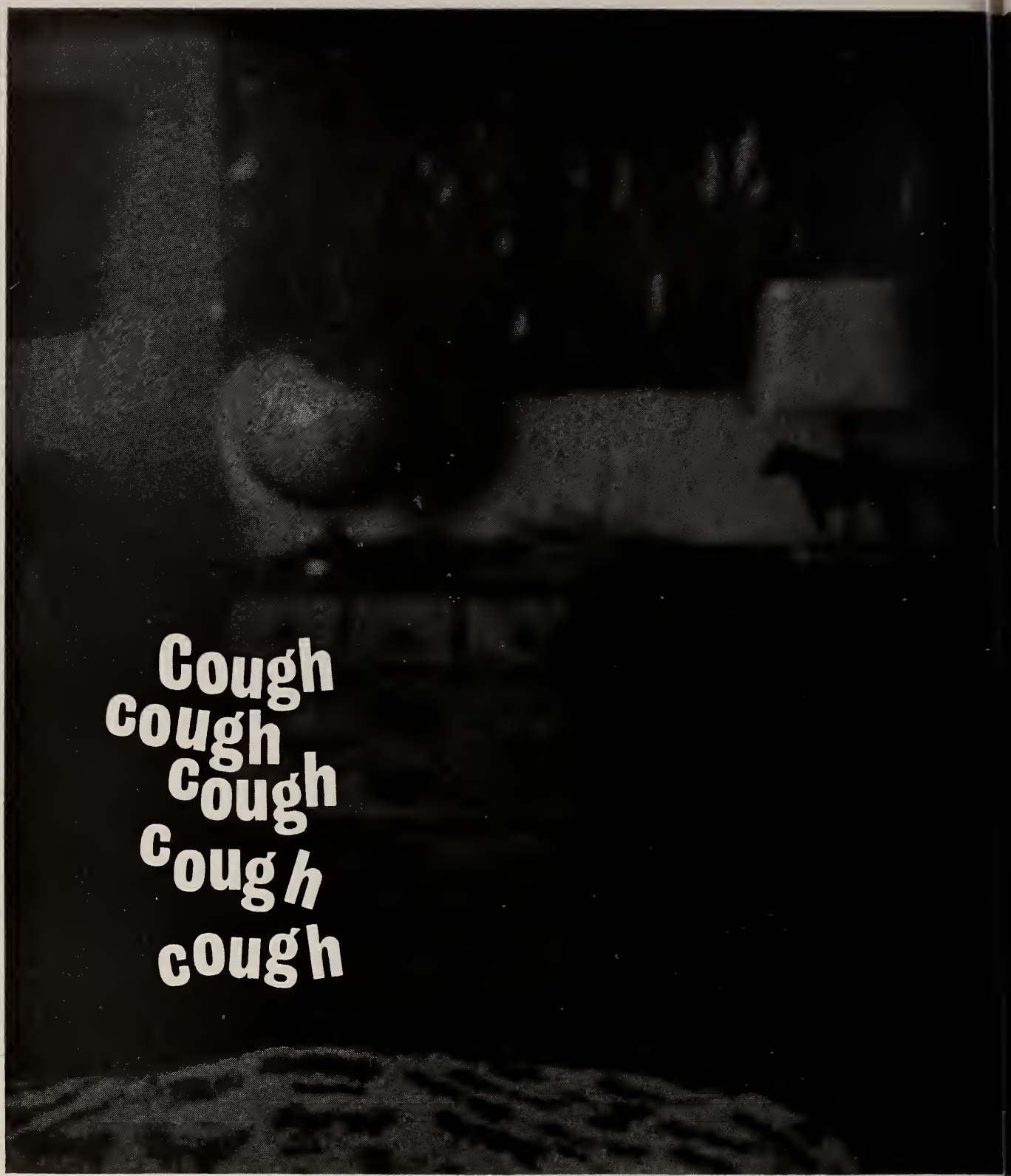
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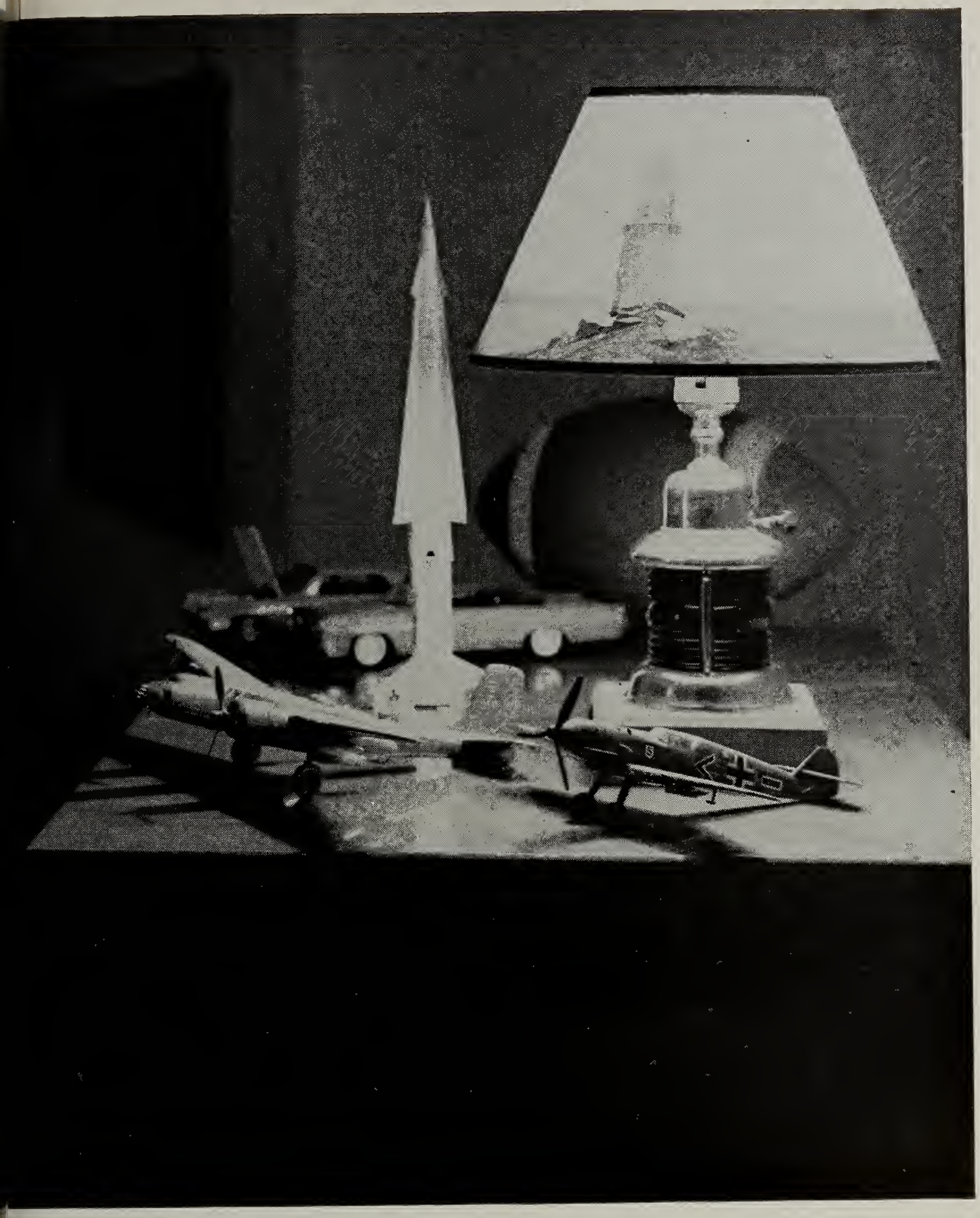
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Gleaned from the British Medical Journal

JACK W. HICKMAN, M.D.
Indianapolis

Abruptio Placenta and Folic Acid Deficiency

This painstaking study covers material derived from 23,043 consecutive deliveries during an eight-year period at the University of Liverpool.[1] The authors made a careful case review to study the incidence and possible causes of abruptio placenta in this patient population. There was an overall bleeding incidence of 2.8 percent, and 1 percent of the total series suffered from abruptio placenta. These figures are in general agreement with numerous other studies. The authors could demonstrate no correlation with preeclampsia and essential hypertension. There was, however, a positive correlation with grand multiparity. They also discovered that the affected patients usually have very unsatisfactory obstetrical histories and that abruptio placenta is apt to recur in succeeding pregnancies. Perhaps the most interesting discovery was that there was a constant relationship between abruptio placenta and folic acid deficiency. As a result of their study, they raised the question of whether prophylactic folic acid therapy during pregnancy should not be considered. The methods of their study regarding folic acid metabolism are quite interesting and bear close evaluation by anyone interested in this field.

Electrolytes in Melancholia

A rather unusual aspect of "melancholia" is reported by Coppen and Shaw.[2] These authors studied the fluid and electrolyte balance in a series of patients who suffered from severe, unremitting depression. A large number of the patients had suicidal tendencies and other somatic manifestations leading to the depressive syndrome. Extremely detailed studies utilizing radioactive isotopes were conducted, which revealed that residual body sodium which included intracellular and serum sodium was very significantly increased during depression. There were no changes in body potassium or plasma sodium, potassium, chloride and hematocrit. The emotional aspects of diseases such as Addison's disease, Cushing's syndrome and myxedema have been well recognized for many years. Although the authors do not speculate as to the particular etiology of their findings, curiosity causes one to speculate on the correlation between their findings and these well-known clinical manifestations.

Splinter Hemorrhages

Splinter hemorrhages are always sought for thoroughly by everyone from sophomore medical students on up. A recent paper by Gross and Tall[3] casts considerable doubt on the value of these physical findings. It has been recognized that they are not pathognomonic of bacterial endocarditis and that they can occur in a variety of other conditions. The present authors found splinter hemorrhages in 19% of 267 patients studied; the highest correlation was in patients whose occupations or activities exposed their hands to frequent trauma. The incidence of splinter hemorrhage decreased with increasing length of hospital stay. The authors suggest that the great majority of splinter hemorrhages therefore, are due to trauma; and a plea for restraint from massive penicillin therapy can be made merely on the presence of these lesions.

Hepatoma in Cirrhosis

An unusually high incidence of hepatoma in cirrhotic patients is reported in a study at St. Thomas Hospital.[4] Apparently, hepatoma has been reported even less frequently in Great Britain than it has been in the United States. The authors found 39 cases of primary hepatoma in the 157 patients with cirrhosis whom they examined at autopsy. These patients demonstrating cir-

Continued

rhosis were from a larger series of 7,366 routine autopsies. Further examinations by five-year periods showed an apparent increase in the discovery of hepatoma. Although physicians are well aware of the occurrence of hepatoma in such diseased liver tissue, the apparent increase and the particularly high incidence in this series cannot be accounted for at the present time.

Anemia after Gastric Surgery

The occurrence of both iron-deficiency anemia and megaloblastic anemia following gastrectomy have been well demonstrated in the past. The present study by Cox et al.[5] adds further support to the development of these anemias. The authors studied a group of 95 patients approximately four years after vagotomy and gastrojejunostomy. Measurement of hemoglobin and serum B-12 levels showed little alteration from normal. However, the serum iron level was found to be reduced in practically all patients. Intestinal absorption studies were done on cobalt labeled vitamin B-12 and the suspected impaired absorption of this vitamin was demonstrated. Even with the impaired absorption, the liver stores of vitamin B-12 are apparently of such huge magnitude to prevent the onset of vitamin B-12 deficiency anemia in these patients for some years after such surgical procedures. This study also confirms the clinical fact that the anemia developing shortly after gastrectomy is usually microcytic in nature.

Cardiac Arrest and Fatal Acidosis

With the sudden resurgence and interest in external cardiac massage, the present study by Stewart is timely.[6] It has been stressed by other authors and confirmed by the present study that the metabolic acidosis that develops following cardiac arrest is extremely lethal and treatment must be as vigorous as the methods used to restore cardiac output. This acidosis was corrected in the present study by the administration of an intravenous sodium bicarbonate solution. The author stresses that if this acidosis is not corrected, the prognosis is greatly impaired and all efforts at artificial stimulation of heart action may be to no avail.

Postoperative Ambulation

Despite the protests of patients, today's surgeon is vigorous in stressing that the patient must be ambulatory shortly after surgery. Browse[7] has measured the body movements of patients throughout their time in the hospital both before and after surgery. As a result of his study, he was forced to conclude that the greatest reduction in activity occurs on admission to the hospital, not at the time of operation. Furthermore, the reduction in calf muscle exercise following surgery is only for a period of 12-24 hours immediately following the operation. Since it is unusual to have thromboembolic complications within the immediate postoperative period, the author concludes that these relatively minor changes in the physical activity are unlikely to be responsible for postoperative deep-vein thrombosis. If, however, a hypercoagulable state follows surgical stress, the author has not evaluated this as a further contributing factor, and this factor especially will need further study.

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Medicine At Law

DECISIONS AND OPINIONS

Highlights of recent court actions pertaining to health and medicine from *The Citation* prepared by the Law Division of AMA.

Government Regulations on Usage of Brand Names of Prescription Drugs Held Invalid—Regulations of the Commissioner of Food and Drugs requiring that every appearance of the brand name of a prescription drug in labeling or advertising be accompanied by the drug's generic name were held invalid by a federal trial court. The regulations were inconsistent, the court said, with a provision of the Federal Food, Drug and Cosmetic Act impliedly limiting the requirement of mention of the generic name to appearance of that name in a prominent place on the drug's label.

The issue arose in an action by drug companies and their trade association for a declaratory judgment as to the validity of the regulations. The court ruled that they were entitled to a declaratory judgment without waiting for enforcement of the regulations, since noncompliance would confront them with substantial imminent harm. The trade association was held to be a proper party to the case, as a representative of the drug firms.

The court's decision was based upon its interpretation of Congressional intent in enacting the labeling provisions of the Food and Drug Act. Under the statute, prominent display of a drug's generic name was required on its label, in type at least half as large as that used for the drug's brand name. The commissioner, in issuing regulations requiring that the generic name appear at every mention of the brand name, was acting inconsistently with the statute. If Congress had intended such a result, the court reasoned, it would not have incorporated the requirement of prominence, since such a requirement would be unnecessary if the generic name appeared with each and every mention of the trade name.

Since the regulations were inconsistent with the statute, they were invalid, the court concluded. Accordingly, a declaratory judgment to that effect was warranted.

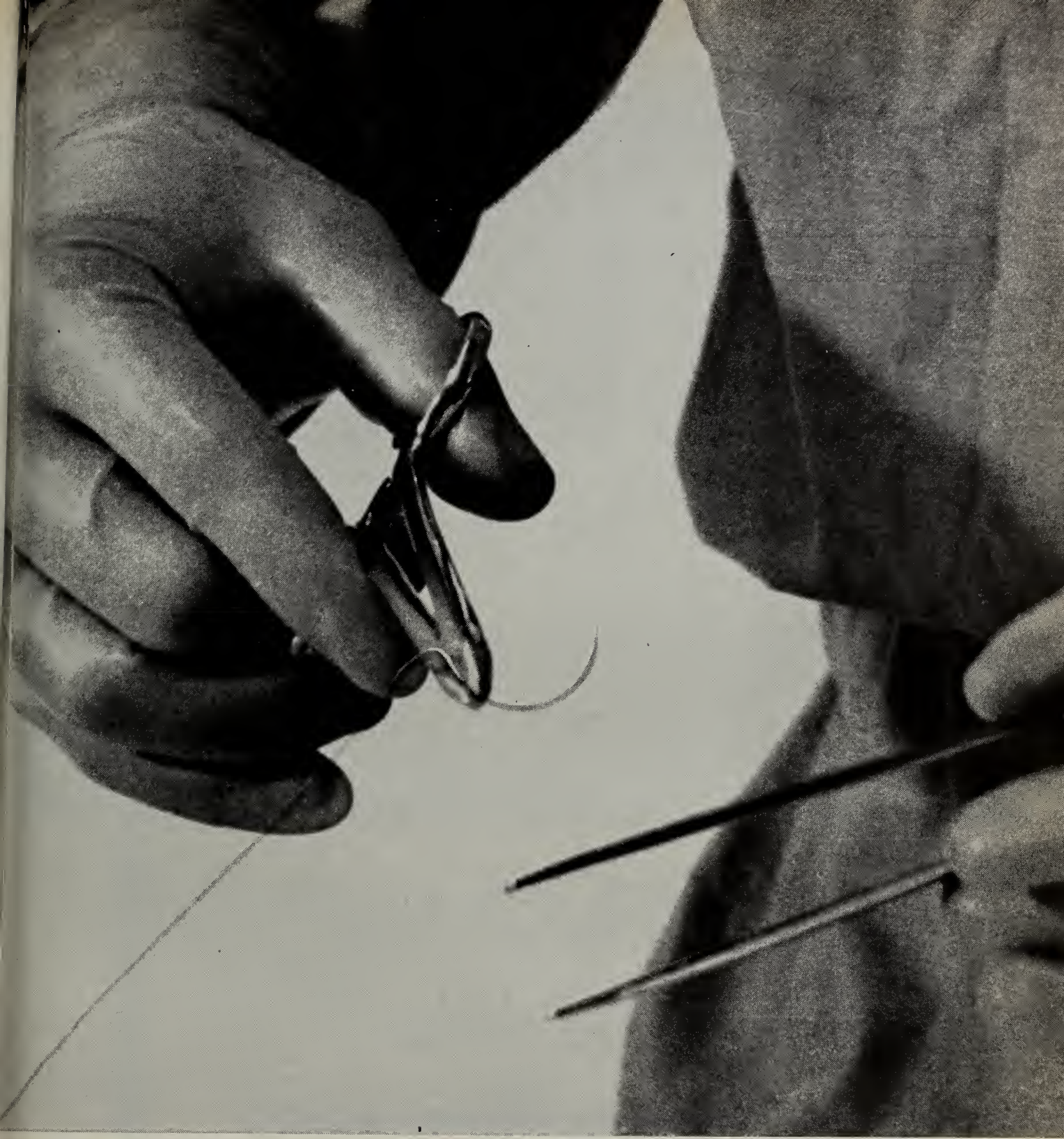
Abbott Laboratories v. Celebrezze, 228 F. Supp. 855 (D.C., Del., April 30, 1964).

Physician Not Liable, Under Civil Rights Act, for Committing Patient to Mental Hospital—A physician was not liable in a suit against him by a patient, based on his alleged violation of the Civil Rights Act, in committing the patient to a state mental hospital, where the physician in committing him acted as a private practitioner, the U.S. Court of Appeals for the First Circuit ruled.

Police officers went to the patient's home after receiving reports of a disturbance there. They arrested the patient because he was violent and apparently irrational. The patient's wife called the physician, who had treated various members of the family for years, to the police station. The physician, after talking to the patient, committed him to a state mental hospital under the procedure prescribed by the state statute.

The patient argued that the physician's action in committing him to the hospital violated the section of the Civil Rights Act which provides that, "Every person who, under color of any statute . . . of any State . . . subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured

Continued



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Continued

. . . ." It was absolutely clear from the record that the physician, in committing the patient, acted as a private practitioner. He was, therefore, not a member of the class exposed to liability by the statutory provision on which the patient based his action, the court said.

Joyce v. Ferrazzi, 323 F. 2d 931 (C. A. 1, Oct. 30, 1963).

Driver Who Drank "Minute" Amount Guilty of Driving While Intoxicated—A driver who was so affected by the ingestion of a "minute" amount of alcohol as to impair his ability to drive in an appreciable degree was properly convicted of driving while under the influence of intoxicating liquor, a Connecticut intermediate appellate court ruled.

The driver was arrested after he crossed the median strip and drove northerly in the southbound lane of a divided highway. He failed the usual sobriety tests. There was a strong odor of alcohol on the driver's breath and he admitted having drunk some beer before his arrest.

When the driver was put in a cell, he pounded on the bars, tore his blanket in strips and threatened to hang himself. The next day he was removed to a hospital where he was examined by a psychiatrist. The psychiatrist testified that, in his opinion, the driver's condition at the time of his arrest was one of "pathological" intoxication, which could probably be produced by drinking a "minute" amount of alcohol and that in a state of pathological intoxication the alcohol cannot be considered the causative agent but is a catalyst, without which the reaction cannot occur.

The law does not distinguish between alcohol as a causative agent and as a catalyst, the court said. The test is the effect which the alcohol had on the driver, rather than the amount he had drunk. The jury found that the driver was so affected by the "minute" amount of alcohol that he had drunk as to appreciably impair his ability to drive. That was sufficient for conviction of the offense of driving while under the influence of intoxicating liquor, the court said.

State of Connecticut v. Holota, 194 A. 2d 69 (Conn., March 18, 1963). ◄

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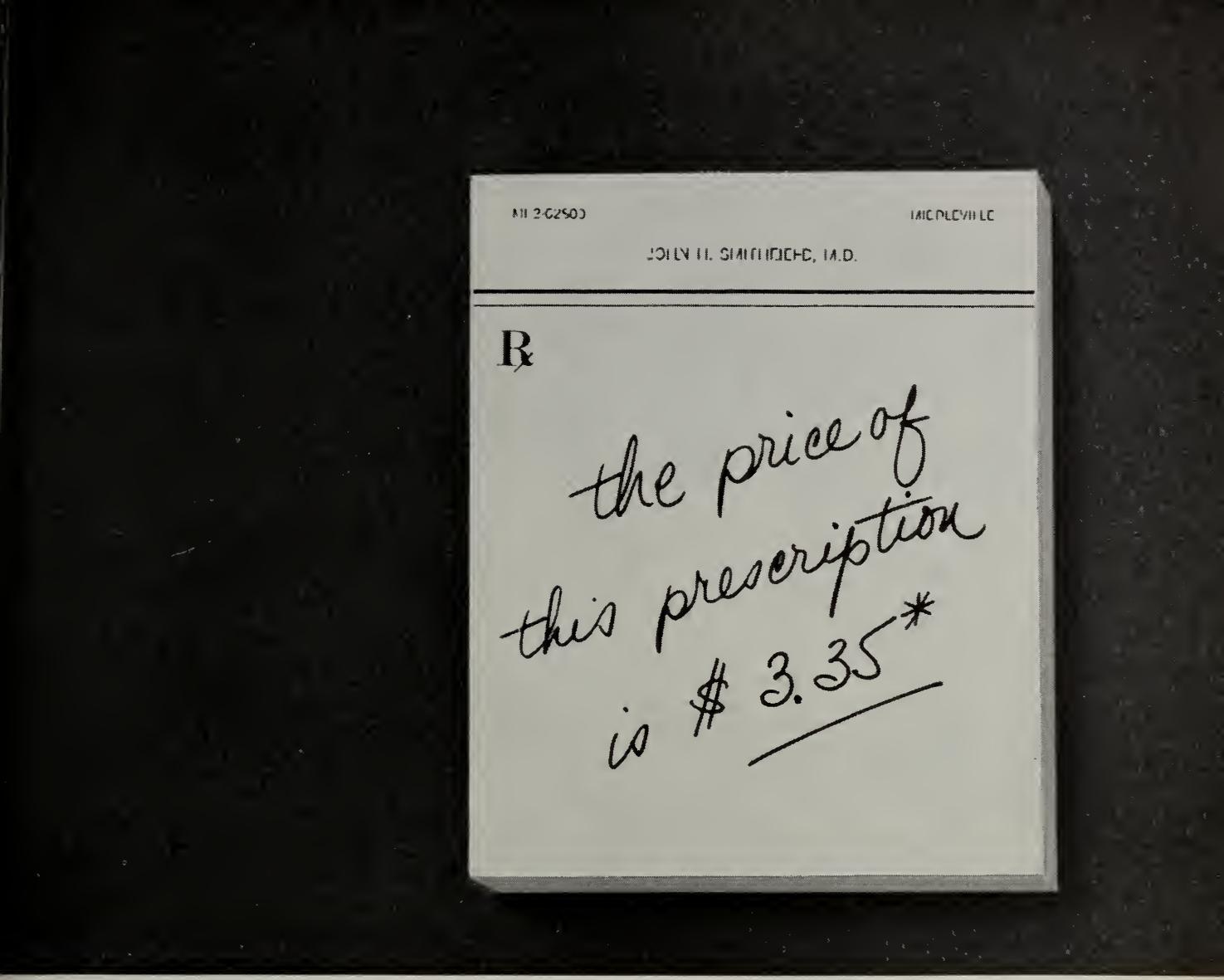
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Disease	Sept. 1964	Aug. 1964	July 1964	Sept. 1963	Sept. 1962
Animal Bites	799	848	1304	733	931
Chickenpox	26	28	125	37	69
Conjunctivitis	96	81	181	44	39
Diphtheria	0	0	1	1	1
Dysentery, Unspecified	47	51	58	197	48
Gonorrhea	361	351	367	304	Not Available
Impetigo	184	240	252	146	202
Infectious Hepatitis	35	24	46	38	54
Infectious Mononucleosis	32	15	45	10	15
Influenza	299	283	217	253	599
Measles (Rubeola-Rubella)	96	133	548	88	57
Meningitis, Meningococcal	5	3	3	6	1
Meningitis, Other	11	4	4	8	3
Mumps	96	158	270	106	57
Pertussis	40	29	79	43	101
Pneumonia	152	118	135	99	61
Poliomyelitis	4	1	1	0	8
Streptococcal Infections	395	345	513	199	297
Syphilis					
Primary & Secondary	6	4	7	2	Not Available
All Other Syphilis	94	109	126	86	Not Available
Tinea Capitis	4	6	6	4	0
Tuberculosis (Active)	89	110	135	79	179

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Letter to the

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August 3, 1964

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By

ARNOLD LIEBERMAN, M.D., Ph.D.
Consultant in Internal Medicine
New York, New York

With a Foreword by
FRANK B. RAMSEY, M.D.
Editor
Journal of the Indiana State Medical Association

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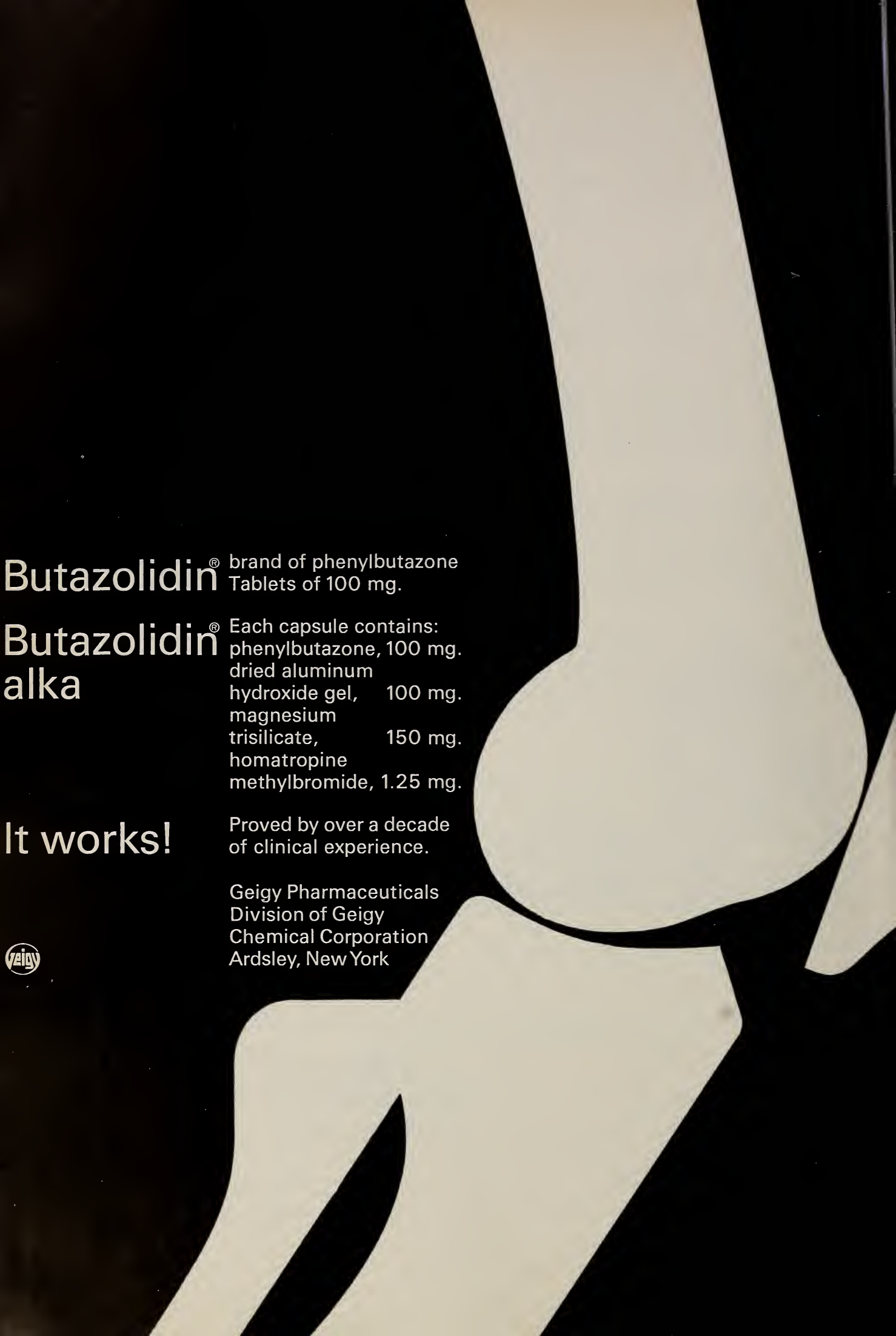
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phenylbutazone, 100 mg.
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magnesium trisilicate, 150 mg.
homatropine methylbromide, 1.25 mg.

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Division of Geigy Chemical Corporation
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Geigy

for the ulcer life:
a new strength of glycopyrrolate

ROBINUL® FORTE
2 mg. per tablet

ROBINUL®-PH FORTE
glycopyrrolate 2 mg. phenobarbital 16.2 mg. (warning: may be habit forming)

When glycopyrrolate was first introduced, clinicians were immediately impressed by the remarkable ability of this compound to exert a more specific pharmacologic action on the gastrointestinal tract than on other organ systems. For example, they often found that in difficult patients the dosage could easily be adjusted upwards to achieve the desired suppression of both hypertonicity and secretion . . . without paying the penalty of side effects intolerable to the patient. Thus, it is no surprise that many clinicians suggested that a double-strength 2 mg. tablet of glycopyrrolate would be both practical and useful. For those patients ordinarily unresponsive to anticholinergics or for those exhibiting the more prominent symptoms, the new Forte dosage forms are a worthwhile addition to your ulcer armamentarium.

BRIEF SUMMARY

INDICATIONS: In addition to its primary indications for duodenal and gastric ulcer, glycopyrrolate is indicated for other G-I conditions which may benefit from anticholinergic therapy. Robinul-PH Forte (glycopyrrolate 2 mg. with phenobarbital) is indicated when these situations are complicated by mild anxiety and tension.

CONTRAINDICATIONS: Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric retention, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH Forte, sensitivity to phenobarbital.

PRECAUTIONS: Administer with caution in the presence of incipient glaucoma.

SIDE EFFECTS: Dryness of mouth, blurred vision, urinary difficulties, and constipation are rarely troublesome and may generally be controlled by reduction of dosage. Other side effects associated with the use of anticholinergic drugs include tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash.

DOSAGE: Should be adjusted according to individual patient response. Average and maximum recommended dose is 1 tablet three times a day: in the a.m., early p.m., and at bedtime.

See product literature for full prescribing information.

Blue Shield Benefits Top Billion Dollar Mark for First Time In 1963

(One of a series prepared by Blue Shield)

Benefits paid by the 83 Blue Shield plans in the United States, Canada and Jamaica topped the billion dollar mark for the first time in 1963. A record 53,450,349 subscribers received $1,066,734,309.

Blue Shield covers 26.41% of the United States population, handling 46% of the medical and 36% of the surgical coverage in this country. Close to 50% of all those with some form of health care prepayment protection in this country have Blue Shield.

Indiana Blue Shield's membership presently totals more than 1,500,000, almost one third of the state's population. During 1963, a total of $23,319,855 was paid out for members doctors' bills. Both membership and payout totals were the largest since the plan was organized.

What causes this large percentage of Americans to turn to Blue Shield as the answer to their medical and surgical prepayment needs?

Is it because Blue Shield is controlled by the medical profession and operates on a nonprofit basis? Or is it because Blue Shield offers coverage to the entire community, paying, for the most part, the major cost of medical-surgical services, with continuous enrollment guaranteed regardless of changes affecting insurability?

Actually, all the above reasons, in varying degrees, play a role in the decision of people to become Blue Shield members.

People choose Blue Shield as their vehicle for prepayment, in part because it is "the doctor's plan." It isn't the doctor's plan in the sense that the doctor owns it, but because he created it, because the medical profession sponsors it and because the doctor is responsible for the success or failure of it.

The fact that the medical profession is responsible for Blue Shield instills confidence in it by Americans who hold the medical profession in high esteem.

The nonprofit aspect of Blue Shield has played a large role in the decision of almost 50 million American to become members. Blue Shield members like the fact that surpluses remaining after a year's transactions are returned to them in broader benefits or better payments for medical-surgical services. Their hard-earned dollars go solely for their own medical care, plus a slight administration expense, rather than to making a profit for someone else.

The fact that Blue Shield plans are community orientated enables many who would otherwise be unable to obtain medical-surgical prepayment protection to enroll. Blue Shield—as an agency of the medical profession—is designed to cover those who need prepayment protection the most . . . this means the low income and poor health groups, in addition to the better risks.

The continuous enrollment guarantee of Blue Shield plans is another reason why many people choose Blue Shield. Members can continue their enrollment regardless of age, changes in employment and health-affecting insurability.

In general, people join Blue Shield because it is geared to their needs. The medical profession, which provides the care, has seen that paying for that care does not become an undue burden upon anyone availing themselves of Blue Shield . . . and Blue Shield is available to all. ◄

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Public Relations Division

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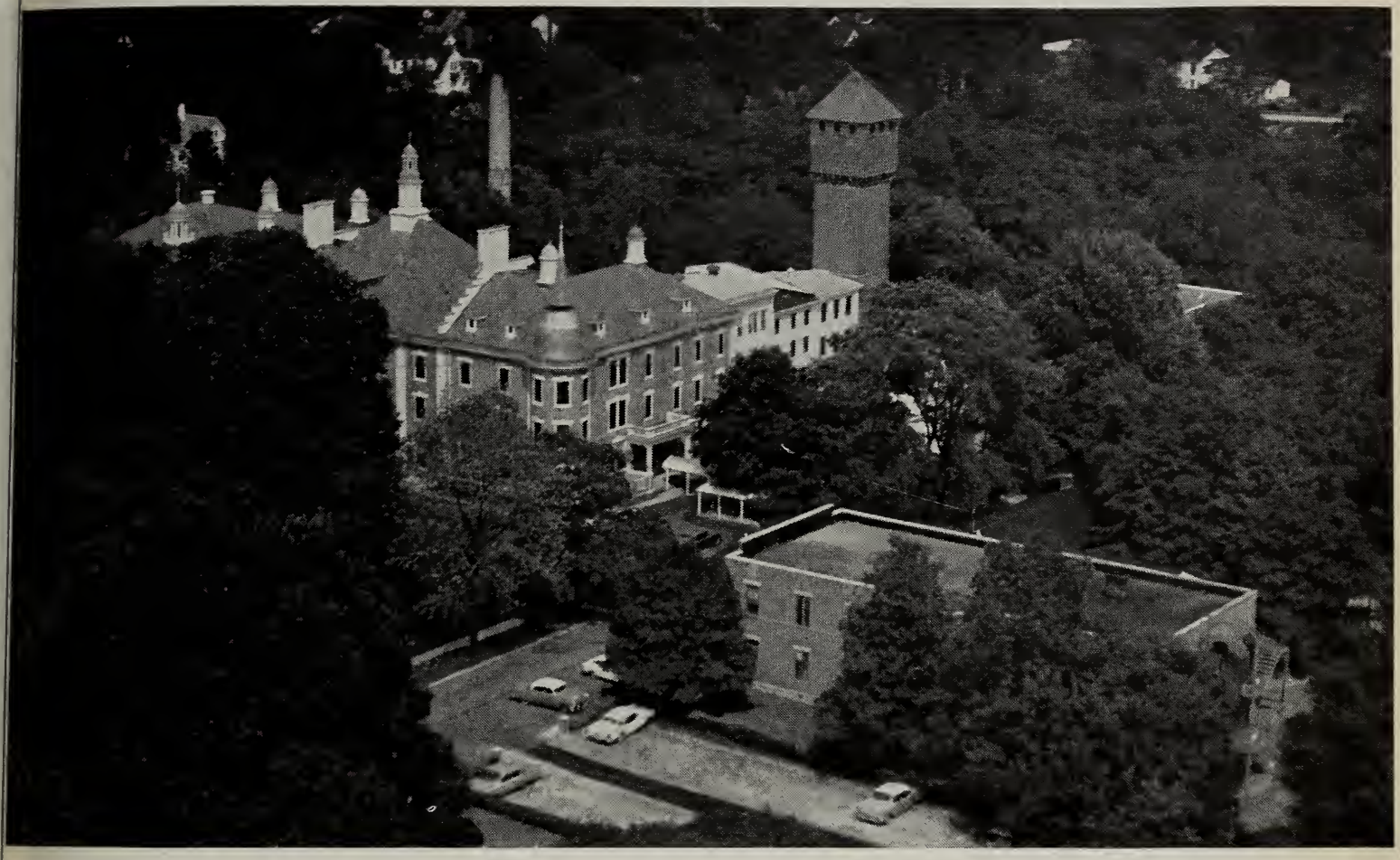
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- Circulation — *metatarsal bars*
- Diabetes — *soft leather shoes*
- Bunions, spurs, corns, callouses — *metatarsal lifts and padding*
- Pigeon-toe, bow-legs — *orthopedic shoes, sole and heel wedges*

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CINCINNATI, OHIO

The Journal Welcomes New ISMA Members

Clarence W. Boone, M.D., *Ob-Gyn,* Indiana University, 1956. (Lake)

John P. Longstaff, M.D., *Psychiatry,* University of Louisville, 1960. (Vanderburgh)

Howard R. Searight, M.D., *Otolaryngology,* University of Illinois, 1953. (Delaware-Blackford)

Lyle P. Siegel, M.D., *Anesthesiology,* Indiana University, 1961. (Vanderburgh)

Leland L. Wince, M.D., *Pediatrics,* Ohio State University, 1961. (Delaware-Blackford)

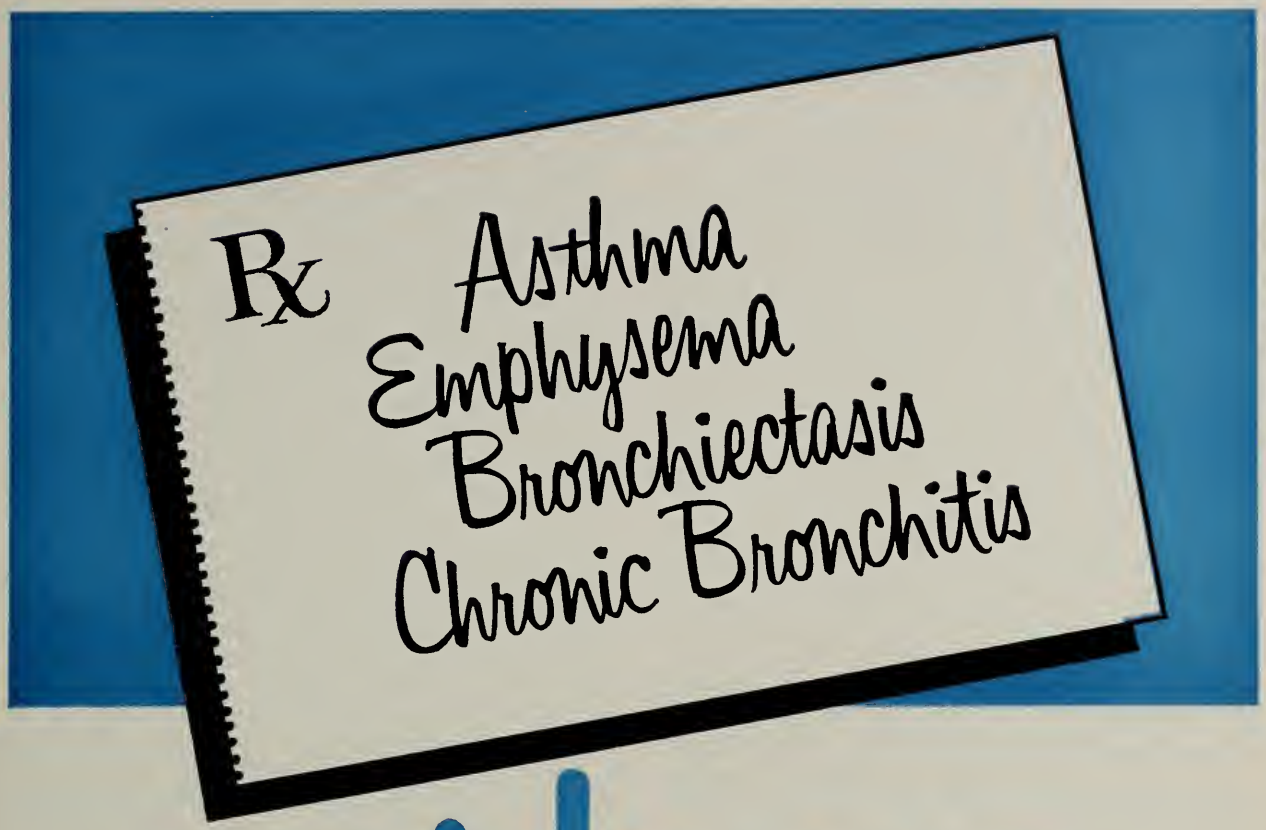
Ray Wolf, M.D., *Staff Physician,* University of Louisville, 1962. (Jefferson-Switzerland) ◄

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In the December Journal



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ABSTRACTS

BOOK REVIEWS

THE PROSPECT OF IMMORTALITY

Robert C. W. Ettinger, Doubleday & Co., Inc., New York, 1964; 190 pages; $3.95.

This book is written by a man who is said to be a teacher of college physics and who has interested himself in studying the possibility of freezing tissues in order to preserve them for use at some future date.

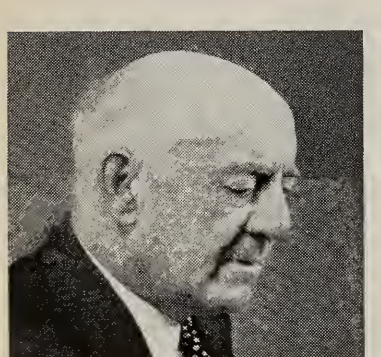
The author has come to regard disease and death as merely manifestations of the failure of medical science as of this date. His prediction is that within the space of some few hundred years, medical science will be able to cure disease by simply removing diseased organs and replacing them with other organs or electronic equipment and thus, by immortality, he means an indefinite life span on this earth.

Needless to say, this raises many complications which are discussed in the various chapters of the book. Not the least of these is the question of the necessity for various religions to adapt themselves to this change. With a twinge of cynicism, he concludes this section with the remark: "When the freezer program gains momentum, religious people, except in scattered instances, are not likely to be left behind."

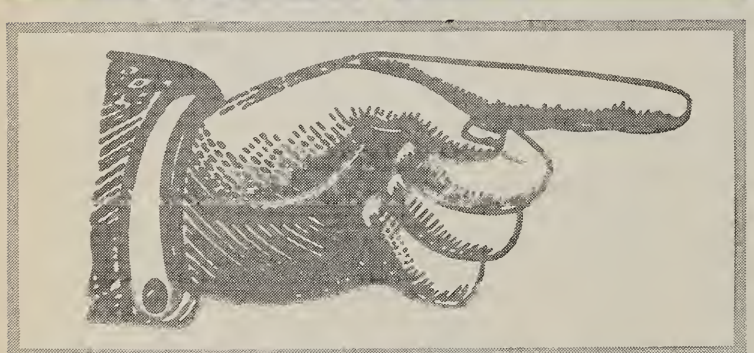
Another sticky problem which this concept raises is the effect of so-called "temporary death" on a marriage. The marriage vow "Until death do us part" will prove to be quite a barrier for the widow when the time comes for her husband to be placed in a deep freeze in a state of "suspended animation" until such time as medical science cares to revive him and restore his health.

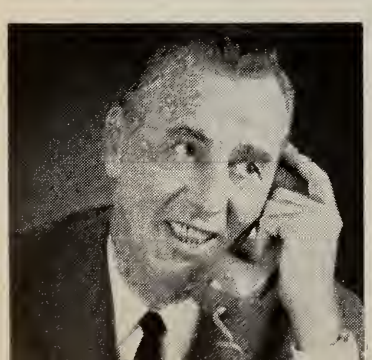
The economics of this type of immortality also receives some attention by the author. It appears quite conceivable that one could be satisfied with acquiring a modest estate, be placed in suspended animation for several hundred years and awake to find his modest estate has grown to the extent that he is a multi-millionaire. This will, of course, be one of the problems of the program that most of its participants would be willing to accept.

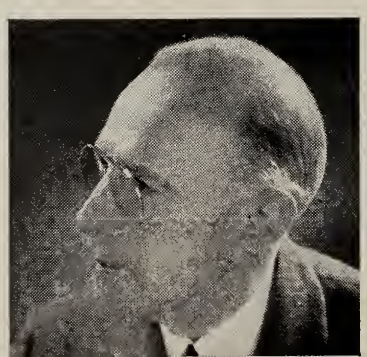
The author's proposition is that communities should organize themselves in a serious fashion and bring pressure to bear on the medical profession and others so that at the time of approaching death or during an incurable disease, they may be frozen, stacked and stored until such time as reanimation is possible and desirable. Admittedly, during the past few decades, we have seen those who have pointed the finger of scorn at science fiction awake to find themselves living with the very things that they denied as possible. Nevertheless, I believe that most physicians who read this



more physicians specify







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book will find themselves willing to run the risk of making that same mistake.

JENE R. BENNETT, M.D.
South Bend

GIVE AND TAKE: THE DEVELOPMENT OF TISSUE TRANSPLANTATION

Francis D. Moore, M.D., W. B. Saunders Co., Philadelphia, 1964, 182 pages, illustrated; $5.50.

This is one of those deceptively simple volumes aimed (presumably) at the lay person; ANY doctor will find it most rewarding reading.

Organ transplantation is no longer a fata Morgana: it is a frontier of medicine that is being expanded at a breath-taking pace. Dr. Moore is an eminent leader in present day efforts in this field.

He is most articulate and limpidly clear in making the baffling (almost) simple! I can recommend this slim volume to just about every person interested in learning.

I saw only *one* typographical error. On page one, third line, the word *expand* is—most obviously—meant to be *expend*. The printing is excellent, the binding is good: the book is well worth its modest price.

ARNOLD LIEBERMAN, M.D.
New York, N. Y.

BETTER HEALTH FOR WOMEN

Charles Richard Alsop Gilbert, Doubleday & Co., Garden City, New York, 1964, 365 pages with illustrations.

From time to time, many popular health books appear but few are authentic and serve a purpose. Physicians today recognize that patients who are informed concerning health matters are more satisfactory to treat, so an authentic and worthwhile manual is always welcomed by physicians.

The author of this volume is a Washington obstetrician and gynecologist whose years of experience have provided him with broad clinical knowledge to supplement his exceptional literary ability. Several prominent obstetricians and gynecologists in the Washington area have collaborated by making valuable contributions to the book. It is divided into twenty-four chapters and has a few pen sketch diagrams displaying female anatomy.

The author covers the vast field of female structure and physiology, the wide range of illnesses peculiar to women and the many problems of women which are important but not strictly illnesses. He discusses all of women's intimate health problems fully, tactfully and frankly. Many topics are discussed in an understanding manner such as: the multi-faceted problem of sex; contraception and sterilization, considered very thoroughly with clear and fair appraisals of the position of various religions concerning this subject; weight control; pregnancy and labor and natural childbirth, which he appropriately appraises as a dying fad.

The book also contains much material which is very useful to mothers of young girls and in-

ysically — its microscopically fine **aqueous** vitamin A
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cludes some marriage counselling. The importance of the early detection of malignancy by symptoms and regular examinations is stressed in a manner not frightening but very convincing. The material is plainly, concisely and clearly written; above all it is sound and authoritative. After each chapter is a question and answer section—very interesting and elucidative.

There is a short bibliography at the end of the text and the volume is also amply indexed. It is in no sense a home medical book; no treatment is suggested or prescribed. This book may well be read by any physician who treats women and merits a place in the library of the home since it covers many areas which the busy physician does not have time to go over with the patient. It is also excellent waiting room reading for the physician's office.

DAVID A. BICKEL, M.D.
South Bend

CHELATING AGENTS AND METAL CHELATES

Edited by F. P. Dwyer and D. P. Mellor, Academic Press, New York City, 1964; 550 pages; numerous illustrations and tables, $17.00.

This is a bringing up-to-date of the original volume in this field by Dr. Mellor. It is a most solid, erudite summation of present day knowledge in this fascinating biological field. When macromolecular medicine will have become a reality, this volume will be found to have been one of the cornerstones making it possible.

Metal enzyme catalysis, hemoproteins and such are rather forbidding topics for even the most knowledgeable of practicing physicians. However, this basic work should be on the shelves of research biochemists, physiologists and the medical personnel exploring the field.

The printing is excellent, errors are invisible, binding is superb. To most of us mere mortals, this material is just indigestible. Yet, we owe a great debt to experts writing just this kind of volume for the edification of their peers to make our present day logarithmic expansion of knowledge possible.

ARNOLD LIEBERMAN, M.D.
New York, N. Y.

Abstracts From Various Literature, Prepared by AMA

THE ROLE OF CASTRATION IN BREAST CANCER

B. J. Kennedy (University of Minnesota Medical School, Minneapolis)

Arch. Surg. 88:743 (May), 1964.

A comparison of the efficacy of prophylactic versus therapeutic castration revealed that the survival interval from initial primary tumor therapy to death was identical for either procedure. Therapeutic castration provides an index of the hormonal responsiveness of breast cancer, and thereby a guide to the selection of secondary therapies. Of patients responding to castration, secondary therapy for reactivated disease produced further improvement in 48% of the patients, but in only 10% of the non-responders. Therapeutic castration appears to be superior to prophylactic castration.

MANAGEMENT OF PATIENTS WITH LONG-STANDING T TUBES IN THE COMMON BILE DUCT

B. J. Ficarra (Postgraduate School, Long Island University, Oyster Bay, N.Y.)

Amer. J. Gastroent. 41:528 (May), 1964.

The author reports his experience in the management of 15 patients in whom a T tube was inserted in the common bile duct and was left there for periods ranging from eight months to three years. The patients had various pathological conditions which produced obstruction of the common bile duct. Emphasis is placed on the care of the T tube and its utilization as a modality for treating cholangitis. The recurrence of stones in the common bile duct within eight to 12 months after surgery in patients with biliary tract disease is a primary motivating reason for leaving the T tube in situ for one year or more. The T tube can be removed when clinical judgment and laboratory data indicate that the liver has returned to its normal physiological capacity and that the biliary tract disease has been eliminated. According to the author, the long-standing T tube in the common bile duct was highly efficient and simple to follow, it has aided the patient, and has given excellent results.

TRAINING OF RESCUE PERSONNEL IN CLOSED-CHEST CARDIAC RESUSCITATION

C. H. Weingarten (330 Brookline Ave., Boston) and L. J. Taubenhaus

New Eng. J. Med. 270:1396 (June 25), 1964.

Police and firemen trained in cardiac resuscitation used the technic with a reasonable degree of safety, but with limited effectiveness. One success and no apparent injuries were noted in 25 attempted resuscitations. Failure to reach the patient within five minutes of circulatory arrest probably precluded success in many cases. A variety of organizational problems which impeded the effectiveness of the program were also identified. Lack of familiarity with resuscitation procedures on the part of physicians was a further obstacle to success in some attempted resuscitations. These findings should be considered in the planning of similar programs, for which there appears to be an increasing demand. Further evaluation of these programs is needed to clarify the role of cardiac resuscitation outside the hospital. ◄

(One of a series of ads being used in key Hoosier newspapers)



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I.U. SCHOOL OF MEDICINE FUND ESTABLISHED

The Alumni Association of the Indiana University School of Medicine in cooperation with the School's faculty and staff have announced the establishment of the I.U. School of Medicine Fund within the Indiana University Foundation.

This year has been designated as VanNuys Memorial Year in honor of the late John D. VanNuys, longtime Dean of the Medical School. Alumni and friends are being given an opportunity to contribute to the newly established Fund for the benefit of the School of Medicine.



D. S. Megenhardt, M.D. Indianapolis

The Fund program has been developed by the officers and council of the Alumni Association and members of the administrative staff and faculty of the School. Dr. Dennis S. Megenhardt of the Class of 1933 has been named national chairman of this year's program, and local chairmen have been appointed in more than one hundred cities throughout the nation. Personal solicitations will be made between November 9 and December 4. It is planned that all alumni of the Medical School will receive detailed information on the program by mail, and many will be personally contacted.

A brochure sent out by Chairman Megenhardt in mid-October to all I.U. School of Medicine graduates outlined the purposes of the campaign with a statement of the urgent needs of the Medical School by Acting Dean John Nurnberger. This material will also go later this year to the members of the Indiana State Medical Association who are not graduates of I.U. Many of these have close relationships with the School of Medicine, and many were friends of Dean VanNuys.

The booklet covers the ways in which alumni and friends may give for the benefit of the School. It explains that the Fund would be structured and administered in such a way that donors of gifts of any size may have a wide variety of choices as to how they can help, knowing that their gifts, small or large, will be used as they wish.

For example, a gift of any size may be directed to help establish and expand the special John D. VanNuys Memorial Fund which is a part of the overall School of Medicine Fund. This specific memorial has as its primary goals the establishment of a professorship and a scholarship program in the name of Dr. VanNuys. Also there are opportunities to contribute to other special funds, such as the long-existing Cyrus J. Clark Memorial Loan Fund and the newly created Betsey Barton Memorial Fund for Neurological Research.

Much interest is developing among alumni and friends of the School in the opportunity to provide scholarships for outstanding students in need of financial aid. Under the scholarship plan a donor may establish a scholarship in his own name or in the name of a relative, friend or teacher. Two new scholarships were created just as the program was getting underway and others are anticipated.

The booklet also points out that unrestricted gifts to the School of Medicine Fund are urgently needed. These will be used for high priority pilot studies and programs of the School of Medicine which could not be initiated without such assistance.

Any person wishing further information or an extra copy of Dr. Megenhardt's booklet should write to Indiana University Foundation, Memorial Union Building Bloomington, Indiana.

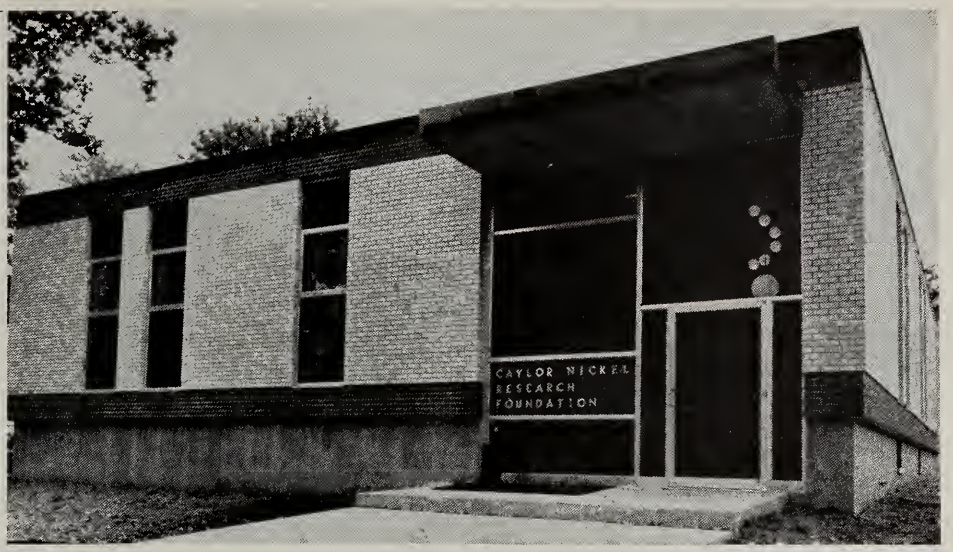
Wyeth Extends Fellowship Program for Eighth Year

Applications are now being received for Wyeth Pediatric Residency Fellowships that will begin on July 1, 1965. Sponsored by the Wyeth Fund for Postgraduate Medical Education, each of these fellowships provides $4,800 over two years toward the advanced study required for board certification.

Those who receive these fellowships select as their place of residency any institution that is accredited by the AMA's Residency Review Committee of the Council on Medical Education and Hospitals, the American Board of Pediatrics and the American Academy of Pediatrics.

Eligible to apply are interns, physicians who have recently completed an internship, research fellows or physicians leaving the armed services or U. S. Public Health Service.

A voluntary committee of distinguished pediatricians has the entire responsibility for selecting the Wyeth Pediatric Fellows. Requests for application forms and inquiries about the program should



THE COMPTON O. RIDER laboratory of the Caylor-Nickel Research Foundation in Bluffton was formally dedicated Sept. 21. The laboratory was made possible by a U. S. Public Health Service research facilities grant and contributions from the clinic and other interested persons.

be directed to the committee chairman, Dr. Philip S. Barba, University of Pennsylvania School of Medicine, Philadelphia, Pa. 19104. All applications must be received by December 1, 1964.

Wyeth Laboratories inaugurated this Fellowship program in 1958 to assist interns and young physicians who want to specialize in pediatrics, who have excellent records in scholastic achievements, who are citizens of the United States or Canada and are of good character, but who find it difficult to finance the required two years of postgraduate training. Wyeth's monthly payments, made directly to recipients, are in addition to the normal stipends paid to residents by the institutions in which they train.

Dr. Boger Appointed

Dr. William P. Boger has been appointed as corporate medical director of Miles Laboratories at Elkhart. Dr. Boger was formerly associated with McNeil Laboratories and with Merck Sharp and Dohme.

American College of Surgeons Names 21 Indiana Fellows

Twenty-one Indiana surgeons became Fellows of the American College of Surgeons during a recent meeting in Chicago. The new class of initiates numbered 1,125 for the entire country. This brings total membership in the college to approximately 26,000.

Those receiving this distinction from the state of Indiana at the 1964 convention are as follows:

George W. Irmscher and Bernard Schwartz, Fort Wayne; John Brincko, William J. Glover and Alfonso D. Holliday II, Gary; P. Kent Cullen, Jr., Fred R. Dallas, Sprague H. Gardiner, Ted L. Grayson, John Duncan MacDougall, Isidore Mandelbaum, John Mealey, Harlan B. Moss, Herschel C. Moss and John A. Waldhausen, Indianapolis; Shokri Radpour, Kokomo; Juan C. Bolivar and Pierre J. Fisher, Jr., USN, Marion; John E. Kerr, Michigan City; Howard B. Brenner, Hammond, and George M. Haymond, Warsaw.

Compton O. Rider Laboratory Dedicated at Caylor-Nickel

The 17th annual fall clinic conference of the Wells County Medical Society was combined this year with the dedication of the Compton O. Rider Laboratory of the Caylor-Nickel Research Foundation Sept. 21 at Bluffton.

Dr. Victor A. McKusick, professor of medicine at Johns Hopkins, gave the major speech at the conference and Dr. John Hickam, professor of medicine at Indiana University, spoke at the dedication services.

The new laboratory houses four chemistry laboratories, a tissue culture laboratory; research conference room, animal quarters, office and space for storage and future expansion. The staff includes a consulting biochemist, a genetic field worker, a chief medical technologist and three additional medical technologists.

The research foundation, which has been particularly interested in human genetic studies, recently received approval of a five-year extension of a U. S. Public Health Service grant entitled "Genetic Studies in Northeastern Indiana."

Drs. Miller, Baxter and McGrath Elected

Dr. Edward D. Miller of Fort Wayne was elected a vice-president and Drs. Neal Baxter of Bloomington and M. F. McGrath of Indianapolis were elected national directors of the Flying Physicians Association at the 10th annual meeting in Palm Springs, California, recently.

Chest Physicians Announce 1965 Essay Contest for Medical Students

The American College of Chest Physicians offers three cash awards to be given annually for the best essay prepared by undergraduate medical students on any phase of the diagnosis and/or treatment of chest diseases (heart or lungs).

The first prize will be $500; second prize, $300 and third prize, $200. Each winner will also receive a certificate of merit. A trophy inscribed with the

name of the winner and his school will be presented to the school.

Since these essay contests were initiated in 1950, cash prizes totaling more than $12,000 have been awarded to students in many parts of the world. Winners will be announced at the 31st annual meeting of the American College of Chest Physicians, to be held in New York City, June 17-21, 1965.

The official application form, sample copies of the journal, and additional information may be secured by writing Mr. Murray Kornfeld, Executive Director, American College of Chest Physicians, 112 East Chestnut St., Chicago, Illinois 60611.

Dr. Heimburger Tours Europe

Dr. Robert F. Heimburger, Indianapolis, Director of Neurological Surgery at Indiana University School of Medicine, is making a tour of U. S. Air Force medical facilities in Europe and northern Africa as civilian consultant in neurosurgery to the Air Force Surgeon General.

"Diet and Arthritis" Manual Published for Arthritis Victims

The Arthritis and Rheumatism Foundation has published a basic manual for arthritis sufferers, "Diet and Arthritis." The booklet stresses that there is no cure for arthritis, nor is there any particular "arthritis diet."

The purpose of the book is to guide patients to healthful and well-balanced meals. Copies are available from the Foundation at 10 Columbus Circle, New York City 10019, or from any of the foundation's local chapters. The foundation also has a 20-page booklet "Osteoarthritis, A Handbook for Patients," which explains the disease and its commonsense treatment in layman's language. This may also be obtained as outlined above.

Dr. Conley on Teaching Trip

Dr. Thomas M. Conley, Kokomo, is currently on an extensive teaching trip on behalf of the Indiana Board of Missions of the Methodist Church and the Far East Christian Council, an interdenominational organization.

Dr. Conley left Sept. 23 for a three-month tour of 15 countries and 41 cities. For the last 14 years, Dr. Conley has been conducting prenatal classes for his private obstetrical patients and for the last six years, he has conducted classes in the Kokomo public schools.

Type E Botulism Antitoxin

The Public Health Service is stockpiling antitoxin to be reserved for use against type E botulism. It will be stored at PHS Communicable Disease Center, Atlanta, Georgia, which will be on 24-hour call for emergency use.

The CDC emergency number is Area Code 404, telephone 634-2561.

North American Pharmacal Artist Will "Characterize" IAGP Meeting

The artist who drew caricatures of physicians at the North American Pharmacal booth at the Indiana state medical convention will return to Indiana March 10 and 11, 1965 for the annual meeting of the Indiana Academy of General Practice.

Mr. Tasco, the artist, will draw caricatures of the board of directors, the executive committee and any other physicians who stop by the booth.

Booklet on Press Relations Now Available to Physicians

A small booklet of 16 pages on the subject of press relations for scientists is obtainable from Smith Kline & French Laboratories.

Originally prepared for use within the SK&F organization, the booklet has become so popular that it has been reprinted and is now being sent upon request to physicians, medical society officers, scientific organizations and hospitals.

It is titled "Scientist, Meet the Press" and subtitled "A Practical Guide to Press Relations for Scientists and Research Managers." Write Smith Kline & French Laboratories, 1500 Spring Garden St., Philadelphia 19101 for more information.

Dr. Kubley Honored

Dr. James Kubley of Plymouth has been presented a commendation and a gift of cuff links and tie clasp by the Marshall County Medical Society in recognition of his prompt and skillful resuscitation of a golfer who was stricken by cardiac arrest while on the Plymouth Country Club golf course.

Dr. Kubley applied closed and open cardiac massage while two other golfers administered mouth-to-mouth resuscitation. The patient was revived and, after being transferred to the Parkview Hospital, has recovered completely.

Dr. Vellios is Speaker

The annual meeting of the American Rhinologic Society was held in Chicago on October 16. A celebration of the society's recent admission to the Council for International Organizations of Medical Sciences was one of the important events of the meeting. The scientific program included a discussion on "The Reaction of Skin and Connective Tissue to Trauma" by Dr. Frank Vellios of Indianapolis. ◄

Annual Meeting Dates of Professional Medical and Allied Organizations

AMERICAN MEDICAL ASSOCIATION CONVENTION
Date June 20-24, 1965
Place New York, N. Y.

AMERICAN COLLEGE OF SURGEONS, INDIANA CHAPTER
Date May 2-5, 1965
Place Aboard the Delta Queen Riverboat, leaving from Cincinnati, O.

BONE AND JOINT CLUB
Date April 14, 1965
Place The Athenaeum, Indianapolis

INDIANA ACADEMY OF GENERAL PRACTICE
Date March 9-11, 1965
Place Murat Temple, Indianapolis

INDIANA STATE SOCIETY OF ANESTHESIOLOGISTS
Date May 15, 1965
Place Indianapolis Athletic Club

INDIANA SOCIETY OF INTERNAL MEDICINE
Date November 22
Place Sheraton-Lincoln Hotel, Indianapolis

INDIANA HOSPITAL ASSOCIATION
Date October 27-29, 1965
Place French Lick

INDIANA NEUROPSYCHIATRIC ASSOCIATION
Date Second Wednesday of every month, October through May
Place The Athenaeum, Indianapolis

INDIANA STATE MEDICAL ASSOCIATION CONVENTION
Date October 13-15, 1965
Place Murat Temple, Indianapolis

INDIANA OBSTETRICAL AND GYNECOLOGICAL SOCIETY
Date November 4
Place Marott Hotel, Indianapolis

INDIANA ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY
Date May 7-8, 1965
Place Oakbrook, Ill.

INDIANA ORTHOPAEDIC SOCIETY
Date May, 1965
Place Indianapolis

INDIANA CHAPTER of the AMERICAN ACADEMY OF PEDIATRICS
Date April 21-22, 1965
Place Marott Hotel, Indianapolis

INDIANA ROENTGEN SOCIETY
Date May, 1965
Place Indianapolis

NORTHERN INDIANA PSYCHIATRIC SOCIETY
Date Fourth Wednesday of every month, September through June
Place For location and program, inquire Beatty Memorial Hospital, Westville



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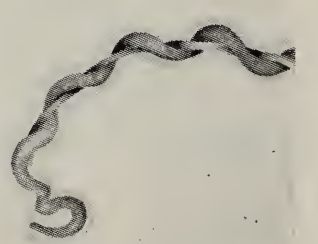
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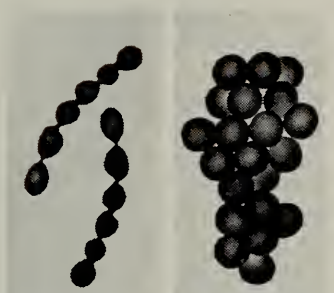


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FUTURE MEETINGS, SEMINARS, COURSES

American Ob-Gyn Board Sets Part 1 Written Exam

The next scheduled Part I (written) examination of this board will be held at various examining centers in the United States, Canada and military bases outside of the continental United States on Friday, December 11, at 2:00 p.m. Candidates eligible to take this examination will be notified on or about November 1 where to appear for examination.

The 1964 bulletin containing detailed information on the requirements and procedure of application in accordance with the new schedule of examinations beginning in 1965, is now available upon request. Bulletins may be obtained by writing to the office of the Secretary, Clyde L. Randall, M.D., American Board of Obstetrics and Gynecology, 100 Meadow Road, Buffalo, New York 14216.

Beginning in 1965, new applicants will be required to submit an application for the Part I (written) examination (together with training verifications) between January 1st and February 28th. Previous applicants (reopened and reexaminees), whose training credits have been approved by the Credentials Committee of this board, may be scheduled for the Part I examination upon written request received no later than February 28th in the year of examination.

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1965 American Industrial Health Conference Will Be April 5-8

The 1965 American Industrial Health Conference will be held April 5-8 at the Americana Hotel in Bal Harbour, Miami Beach, Fla.

This medical-nursing conference, which is comprised of the annual meetings of the Industrial Medical Association and the American Association of Industrial Nurses, will bring together approximately 2,000 persons. In addition to industrial physicians and nurses, industrial hygienists, safety engineers, public health officials, military service medical personnel, university faculty members, management representatives and others who have an interest in the health of the working population will attend.

The scientific program, in which many of the nation's experts in the field of occupational health will participate, will be augmented by both scientific and technical exhibits. Intensive courses in selected areas of medical practice also will be presented. Further information about the Conference may be obtained by writing American Industrial Health Conference, 55 East Washington St., Chicago, Ill. 60602.

Course in Ophthalmology Scheduled by Cleveland Clinic

The Cleveland Clinic Educational Foundation will present a postgraduate course in ophthalmology December 9 and 10 in Cleveland.

Further information on the course may be obtained from the Education Secretary, Cleveland Clinic Educational Foundation, 2020 E. 93rd St., Cleveland 44106.

General Practice Review Set By University of Colorado

A general practice review will be held by the University of Colorado in Denver on January 17 to 23, 1965. This is the eleventh such annual meeting.

It will hold forth for a full week, with each day devoted to a different important area of practice. Further information and detailed program is available by writing University of Colorado School of Medicine, 4200 E. 9th Ave., Denver 80220. ◄



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County, District News

Fifth District

The Fifth District Medical Society met Sept. 16 at Brazil for its annual meeting.

Dr. Burton Scherb was elected president; Dr. William Strecker, vice-president and Dr. Robert Brown, secretary-treasurer. All of the new officers are from Terre Haute. Dr. A. W. Cavins was re-elected alternate councilor and Dr. Hubert T. Goodman was re-elected Blue Shield representative. Dr. Joe M. Black, Seymour, gave a short talk and Mr. George W. Eggleston, vice-president and trust officer of the Indiana National Bank at Indianapolis, spoke on "Estate Planning and Wills."

Eleventh District

Dr. Fred C. Poehler, La Fontaine, was elected president of the Eleventh District Medical Society at its meeting Sept. 16 at Wabash.

Dr. Max M. Earl, Kokomo, was elected secretary-treasurer. Dr. K. O. Neumann, Lafayette, discussed the upcoming convention and Dr. Roy Behnke of Indianapolis spoke on the role of Indiana University in the present training program at the medical school in Karachi, Pakistan.

Clinton

Field Secretary Howard Grindstaff met Sept. 22 with the Clinton County Medical Society to discuss the King-Anderson bill, the ISMA convention and resolutions which would be presented at the state meeting.

Daviess-Martin

The Daviess-Martin County Medical Society met Sept. 21 in Washington, Ind. Field Secretary Robert Amick met with the group to report on the King-Anderson bill and the ISMA convention.

Fort Wayne

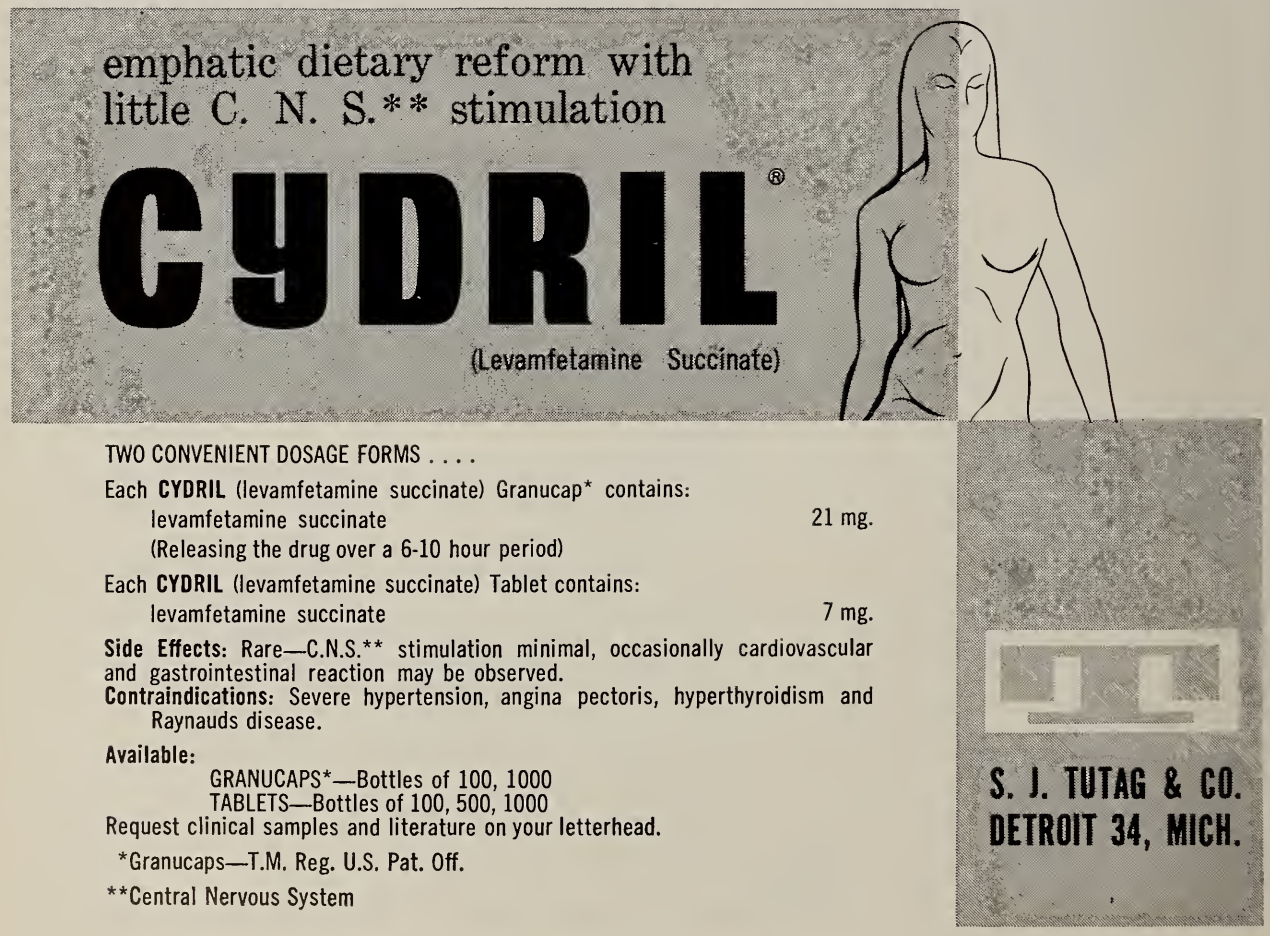
Dr. Karl M. Pfuetze, general administrator of the Suburban Cook County Tuberculosis Sanatorium District, spoke on "Modern Treatment of Tuberculosis" at the Sept. 1 meeting of the Fort Wayne Medical Society. There were 82 members present.

Lake

Eighty-five members of the Lake County Medical Society met Sept. 9 to hear Dr. George Pickett, Washington, D. C., medical officer for the smoking control program of the United States Public Health Service. His topic was "The Surgeon General's Report on Smoking."

Miami

Dr. L. L. Hill read and discussed resolutions to



be voted on at the House of Delegates meeting in October before the Sept. 29 meeting of the Miami Medical Society.

Owen-Monroe

The Owen-Monroe County Medical Society met Sept. 24 at Bloomington. Speaker was Mr. Howard Brown, freshman coach at Indiana University, who discussed the present physical training set up at I.U.

Pulaski

Dr. Henry R. Eshelman, Monterey has been elected president of the Pulaski County Medical Society. Assisting him will be Dr. William R. Thompson, Winamac, as secretary-treasurer.

Wells

"Genetic Research in the Service of Clinical Medicine" was the topic chosen by Dr. Victor A. McKusick of John Hopkins when he spoke at the Sept. 21 meeting of the Wells County Medical Society. There were 62 members present. ◄



I think I'm getting somewhere as a witch doctor. I was able to make out two whole words in the last copy of THE JOURNAL of the Indiana State Medical Association.

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Deaths

Daniel S. Adams, M.D.

Dr. Daniel S. Adams, retired Indianapolis physician, died Oct. 10 in Ft. Myers, Fla. He was 88.

Graduated from the Indiana Medical College in 1905, Dr. Adams was a general practitioner until 1919 and then limited his practice to ear, eye, nose and throat after taking postgraduate work in New York and Vienna. He practiced medicine in the Indianapolis area for more than 55 years.

Dr. Adams retired five years ago and had made Ft. Myers his home since that time. He was a member of the Marion County Medical Society, a Senior Member of ISMA and a member of the 50-Year Club.

Ralph C. Eades, M.D.

Dr. Ralph C. Eades, prominent physician and surgeon, died July 19 in Valparaiso on his 63rd birthday.

Known in Valparaiso and surrounding area as a physician and surgeon for 30 years, Dr. Eades previously had been a teacher, coach, umpire, referee and minister. He was graduated from Loyola University in Chicago in 1934 and went to Valparaiso where he set up his office.

Dr. Eades was one of the foremost exponents and supporters of the Northwest Indiana Regional Science Fairs and served as a judge at the International Science Fairs for many years.

A member of the Porter County Medical Society, Dr. Eades had been an ISMA delegate, alternate councilor and secretary of the Porter County Medical Society.

William E. King, M.D.

Dr. William E. King, 65, internal medicine specialist, died Oct. 15 at Indianapolis.

Dr. King, who taught school at Colfax and Kirklin before receiving his bachelor's and doctor's degrees at Indiana University, also did postgraduate work at the University of Pennsylvania. He was a member of the staffs of Methodist, where he was chief resident physician from 1929 to 1931 and Community Hospital. He was a member of the Marion County Medical Society.

Clement L. Poston, M.D.

Dr. Clement L. Poston, staff member of the Fayette Memorial Hospital at Connersville, died Oct. 14 at Orly Airport in Paris, France while awaiting an airplane to return him to the United States.

Dr. Poston, 64, was graduated from the Indiana University School of Medicine in 1928. He lived at Laurel, Ind. and was a member of the Fayette-Franklin County Medical Society. ◄

In the December Journal

Complete coverage of the 1964 ISMA Annual Convention, including business proceedings of the House of Delegates and a picture story of convention events.

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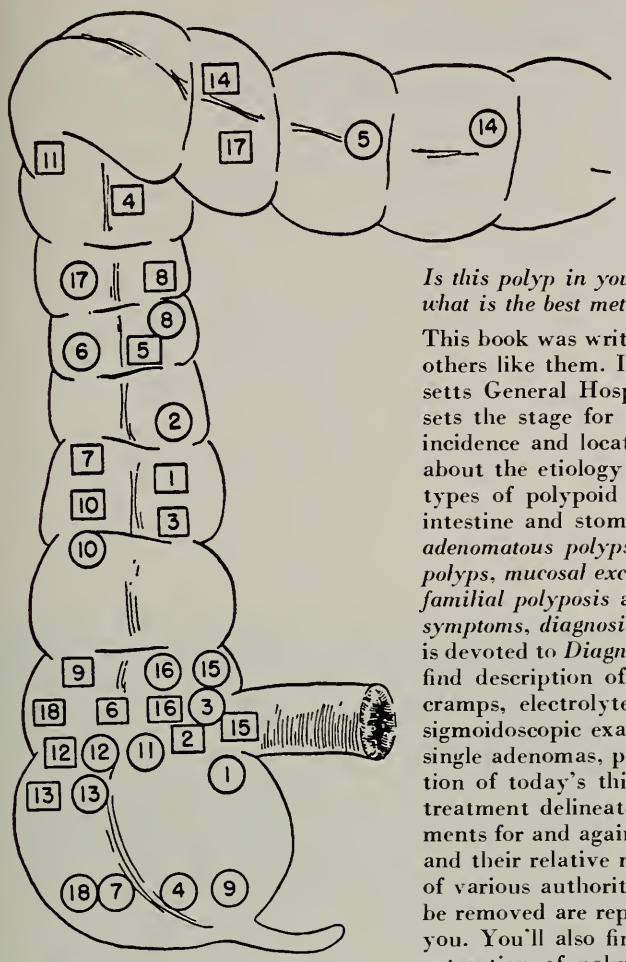


Figure 3-25. *Location of cancer and simple adenomas in resected cancers of the right colon. Squares locate cancers; circles, adenomas.*

Polypoid Lesions of the Gastrointestinal Tract
by Claude E. Welch, M.D.

Is this polyp in your patient benign or malignant? Should it be removed? If so, what is the best method for this particular lesion in this particular patient?

This book was written to help you answer questions such as those above, and others like them. Its author has drawn on the experience of 1124 Massachusetts General Hospital patients, plus many personal cases. Dr. Welch first sets the stage for a fruitful discussion by defining terms, by discussing the incidence and location of polypoid tumors, and summarizing what is known about the etiology of adenomas. He then proceeds to illuminate the various types of polypoid lesions you'll encounter in the colon and rectum, small intestine and stomach. He describes and illustrates common lesions such as *adenomatous polyps* and *papillary adenomas*, and such rare ones as *pseudopolyps, mucosal excrescences, Peutz-Jeghers polyps*, etc. *Multiple polyposis* and *familial polyposis* are also completely covered. *Etiology, incidence, pathology, symptoms, diagnosis, prognosis, treatment*, are clearly set forth. A full chapter is devoted to *Diagnosis of Polypoid Lesions of the Colon and Rectum*. Here you'll find description of symptoms (bleeding, change in bowel habit, abdominal cramps, electrolyte imbalance, etc.) and physical findings from palpation, sigmoidoscopic examination, and radiologic examination. The relationship of single adenomas, papillary adenomas, and cancer is discussed, with examination of today's thinking on the adenoma-cancer relationship. A chapter on treatment delineates location and identification of polyps, giving you arguments for and against their removal. Polypectomy and resection are discussed and their relative merits contrasted. If resection is decided upon, the opinion of various authorities as to the amount of bowel and mesentery that should be removed are reported. The author states his own conclusions to help guide you. You'll also find helpful consideration of sub-total and total colectomy, extraction of polyps via the anus, posterior proctotomy, resection of the rectum, and sigmoidoscopic removal of polyps.

By Claude E. Welch, M.D., Visiting Surgeon, Massachusetts General Hospital, Boston; and Clinical Professor of Surgery, Harvard Medical School, Boston. 118 pages, 6⅛" x 9¼", illustrated. $7.50. *New—Just Ready!*

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Child—*The Liver and Portal Hypertension*, was the first volume in this series, published June, 1964. Future volumes are scheduled to cover: *Trauma to the Liver—Surgical Problems of the Pancreas—Peripheral Arterial Disease.*

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DECEMBER 1964

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EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members. Cost of color illustrations must be shared by the author.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible. However, the right is reserved to reduce in length or reject any article.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication in THE JOURNAL of the Indiana State Medical Association.

Communications dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 1802 North Illinois Street, Indianapolis 2, Indiana. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 3935 N. Meridian, Indianapolis 8.

Advertising rates will be furnished on request. Copy must be received by the 5th of the month preceding month of issue. (Scientific manuscripts must be received at least two weeks earlier if geared for a specific issue.)

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About Our Cover on page 1337.

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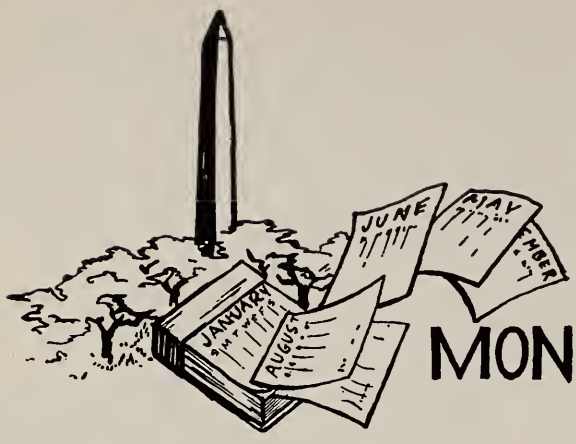
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This summary of what is happening in Washington is prepared by A.M.A.'s Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

MONTH IN WASHINGTON

WASHINGTON, D. C.—The Johnson Administration has placed so-called Medicare at the top of its legislative program for 1965.

In a policy paper issued a few days before the national elections, President Johnson said:

"First we must provide adequate hospital and nursing home care for our senior citizens by a sound program financed through contributory social insurance. I pledge that the legislation to accomplish this will head my program next year."

Administration forces in Congress expressed confidence that most of Johnson's legislative program would be approved next year in light of the Democratic victory in the elections. Democrats gained a net of 37 seats in the House.

The Administration was reported to be considering a program that would be financed by a separate employer-employee tax rather than an increase in the Social Security tax as called for in legislation that died in a House-Senate conference committee when Congress adjourned in October.

In reiterating his opposition to Social Security financing, Rep. Wilbur D. Mills (D., Ark.), chairman of the Ways and Means Committee, said just prior to adjournment:

"I think one of the difficulties that has actually impeded the reaching of a sound solution is the insistence by the proponents of medical care on proceeding toward a solution through the existing OASDI (Social Security) system rather than in an all-out effort to solve the problem itself with some flexibility in their approach. In other words, there may well be within our reach solutions to the admittedly difficult and increasing problems of medical care for the aged which lie outside of attaching a Federal program to the framework of the OASDI insurance system. . . .

"I would be hopeful that the basic prepayment concept might lead us in the direction of sound approaches to this matter. There are other principles which we can embody to insure a sound medical program while at the same time preserving our basic Social Security insurance system."

Other points listed in Johnson's policy paper on health were:

"Second, we must step up the fight on mental health and mental retardation.

"I intend to ask for increased funds for research centers, for special teacher training and for helping coordinated state and local programs.

"Third, we must expand our program to help train the doctors, dentists and technicians this nation desperately needs. Right now, the statistics show that we are importing interns and resident physicians from other countries which can ill afford to lose them.

"Fourth, we must enlarge programs to help disabled citizens rehabilitate themselves for useful employment.

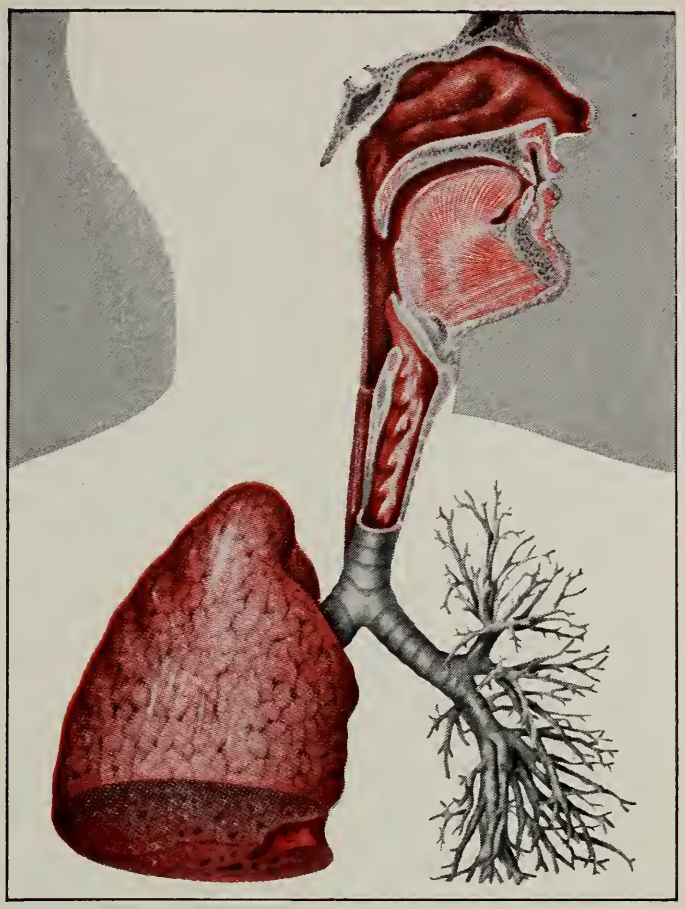
"Fifth, we must increase existing programs of medical assistance to children of low-income families.

"Sixth, we must work to correct the deficiencies of young men who are rejected for military service because of health.

Continued

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CAUTION: Should be used with caution in patients with known idiosyncrasies to phenylephrine hydrochloride and in those with moderate or severe hypertension, hyperthyroidism or advanced arteriosclerosis. In these patients the use should not exceed three days. Hycomine* Syrup is generally well tolerated but in some patients drowsiness, dizziness or nausea may occur.

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"Seventh, we must move ahead in the effort to protect the purity of the water we drink and the air we breathe. Air pollution, according to one estimate, causes $11 billion damage each year to property alone. No one can measure the damage to our children's lungs."

$35 MILLION FOR MENTAL HEALTH CENTER CONSTRUCTION

A total of $35 million in Federal funds has been appropriated to help finance construction of community mental health centers in 1965.

It is the initial allotment of funds for a $150 million three-year program of Federal grants-in-aid for building such centers. Grants will range from one-third to two-thirds of total construction costs.

The Department of Health, Education and Welfare said the centers built in 1965 will form the nucleus of the new national mental health program to provide comprehensive treatment of the mentally ill in the patients' home communities.

Grants will be administered and awarded to eligible sponsors of the centers by the National Institute of Mental Health of the Public Health Service under terms of the Community Mental Health Centers Construction Act of 1963 (Public Law 88-164).

The centers must provide a minimum of the following five essential services to patients: in-patient treatment, out-patient treatment, partial hospitalization, with around-the-clock emergency service available in at least one of these. Centers must also provide consultation and educational services to community agencies.

In addition to the construction funds for centers, NIMH will grant $12 million in 1965 to hospitals for the mentally ill and for the mentally retarded to improve treatment and care of patients.

NIMH also will award $6 million in inservice training grants during 1965 to upgrade skills of hospital personnel in providing comprehensive care for patients.

Other funds available to NIMH under the regular mental health appropriation of 1965 include $163.7 million for research, fellowships, training of professionals and state grants and $24.2 million for institute research and items of direct operations.

HEART SURVEY RESULTS PUBLISHED

About two of every 15 American adults have definite heart disease and an additional one of nine have suspect heart disease, according to the Public Health Services National Heart Survey.

The survey comprised a sampling of 7,710 adults with 6,672 given physical examinations from 1959 through 1962. Major projected findings included:

—Of the 111.1 million American adults, 14.6 million have definite heart disease and 13 million have suspect heart disease. Of every 100 persons aged 18 through 79, 13.2 had definite heart disease and an additional 11.7 had suspect heart disease.

—Most commonly encountered was hypertensive heart disease. More than 10 million Americans suffer from it, and nearly 4.8 million others have suspect hypertension.

—Coronary heart disease accounts for 3.1 million definite and 2.4 million suspect cases.

—Women are more likely to have definite hypertensive heart disease; men are more likely to have definite coronary heart disease or heart disease of congenital or syphilitic origin. Suspect hypertensive heart disease is more common in men than in women; suspect coronary disease more common in women than in men.

—About 24.4% of Negro adults have definite heart disease, twice as high

as the incidence for white adults.

—The prevalence rates for suspect heart disease are 14.8 and 11.3%, respectively, for Negro and white.

—The prevalence of heart disease rises sharply with age. Less than two percent had definite heart disease in the 18-24 age group.

—About 39% of the men and 46% of the women in the 75-79 age group have definite heart disease.

—A large number of persons with heart disease have more than one manifestation. ◄

About Our Cover



Christmas is a reflection of many things — the magical enchantment of the tinseled and bedecked windows, trees and stores, the love of us all for one another and the rapture in the eyes of a child on Christmas morn.

But reflected in the Christmas ball on this month's cover is the true meaning of Christmas — the adoration of the Christ Child who was born this day.

James Whitcomb Riley expressed it completely — as only he could — in his "Child's Christmas Carol":

Christ used to be like you and me,
When just a lad in Galilee, —
So when we pray, on Christmas Day,
He favors first the prayers we say:
Then waste no tear, but pray with cheer,
This gladdest day of all the year:

O Brother mine of birth Divine,
Upon this natal day of Thine
Bear with our stress of happiness
Nor count our reverence the less
Because with glee and jubilee
Our hearts go singing up to Thee.

The editor and staff of *The Journal* wish one and all the happiest of Christmas celebrations and only good wishes for the new year.—J.F.S.



LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Tommy Hendricks

To have a lived a full life, and to have retained one's curiosity and usefulness to the very end. These are aspirations to which anyone in his twilight years might profitably cling. Few, however, achieve them in quite the grand style that Thomas A. Hendricks did.

Tom Hendricks, Hoosier sportsman, newspaperman, politician and a national spokesman for the medical profession, died at Chicago a few days ago at the age of 70. Born to an exciting, transitional period of American history, he was never content to be a mere bystander.

A boyhood chum of Booth Tarkington, Hendricks was part of the inspiration that the Indianapolis author was to draw upon later in writing his famous Penrod and Seventeen stories. And, as a reporter on both *The Indianapolis Star* and *The Indianapolis News,* he rubbed elbows with authors Meredith Nicholson and George Ade and Senator Albert Beveridge. An enthusiastic sportsman, himself, he rode at the Indianapolis Motor Speedway with Howdy Wilcox and Ralph DePalma and played tournament tennis with Big Bill Tilden and was squash champion at the Indianapolis Athletic Club.

Tommy Hendricks rode in the country's first horseless carriage with Kokomo inventor Elwood Haynes and, with his brother, Blythe, he was credited with making the first radio broadcast of an Indiana basketball game. After his fruitful newspaper career he moved into the political area, serving in both the Indiana Senate and the House of Representatives. Later he became an affable and articulate spokesman for the medical profession, first at the state level and then as secretary to the American Medical Association's Council on Medical Services.

They were fast-moving years and ever-curious, friendly Tommy Hendricks left his imprint on a dozen fields of endeavor that most of us were content to sit and observe in passing.—*Indianapolis Star,* Nov. 7, 1964.

Thomas A. Hendricks

The bearer of a famous name in Indiana history had given it an added luster in the 70 years of his life which ended this week.

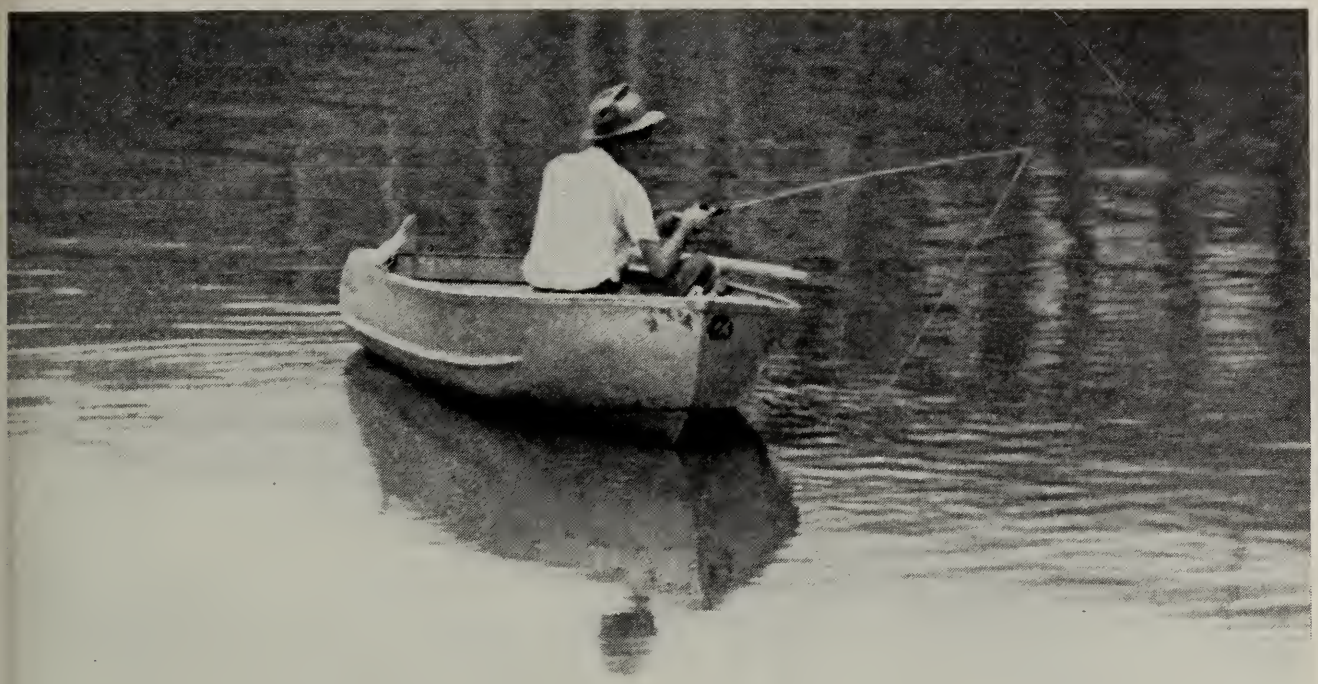
The man was Thomas A. Hendricks, whose great-uncle of the same name was a United States senator from Indiana and vice-president. News of his death in Chicago came as a shock to his countless friends in Indiana.

Tommy Hendricks is remembered as a good newspaperman who was a former member of *The News* staff. He was an authority on sports and maintained his enthusiasm for athletics throughout his life. He was a pioneer radio broadcaster and for a time ventured into politics to serve one term each as state representative and state senator.

Hendricks, as executive secretary of the Indiana State Medical Association, built it into one of the most active in the nation. He later served as secretary of the council on medical services of the American Medical Association and then became assistant to the association's executive vice-president.

A listing of his activities cannot convey the friendliness of the man or his great zest for life. He will be long remembered with

Continued



The discharged mental patient... and Thorazine®

brand of chlorpromazine

"The average practitioner is quite capable of handling the vast majority of ex-institutionalized patients by regulation of medication, reassurance, manipulation of the environment where necessary, and . . . other technics." Kline, N.S.: Postgrad. Med. 27:620 (May) 1960.

The family physician must often assume responsibility for the discharged mental patient. Thorazine (chlorpromazine, SK&F) can be a valuable adjunct to the continuing care of this patient, because it helps prevent relapses by insulating him from the impact of stressful experiences. For successful rehabilitation and prevention of rehospitalization, however, the former mental patient—and often his family—also needs the guidance and counsel of his physician.

Many physicians are surprised by the high doses of Thorazine (chlorpromazine, SK&F) used in patients released to their care from mental hospitals. This surprise may be expressed by a drastic reduction in dosage "to play it safe"—with serious consequences for the patient.

The successful maintenance of former mental patients requires adequate, often "high" dosage, and often for prolonged periods of time. Fortunately, these dosages do not mean greater risks for the patient. On the contrary, there is much less risk of serious side effects once a patient has become gradually accustomed to Thorazine (chlorpromazine, SK&F)—*regardless of dosage*—over a period of a few months. Continuing therapy is almost always well tolerated, and is essential to most patients' continued well-being.

Brief Summary: Thorazine (chlorpromazine, SK&F) has been successfully used for 10 years in the treatment of mental and emotional disturbances, and has proven highly effective in the maintenance therapy of former hospitalized mental patients. *Principal side effects:* The most frequently encountered side effect is transitory drowsiness. Other occasional side effects include: dry mouth, nasal congestion, constipation, miosis, dermatological reactions, photosensitivity, jaundice, hypotension, increased appetite and weight; very rarely, mydriasis, agranulocytosis, extrapyramidal symptoms. *Contraindications:* Comatose states or in the presence of excessive amounts of C.N.S. depressants.

For complete prescribing information, please see *PDR* or available literature.

SK&F *Smith Kline & French Laboratories*

affection and respect.—*Indianapolis News*, Nov. 4, 1964.

Alicia In Terra Mirabili

One of the items among the autumn publications listed by Macmillan's of London is "Alicia in Terra Mirabili," a work that we commend to politicians of every persuasion in this tumultuous year.

If their Latinity has weakened with the years, here is a good way to rejuvenate it and at the same time improve their perspective. If their vocabulary is very, very weak, they can use the English crib perhaps already known to them as "Alice in Wonderland." It is a cheering thought that enough people still relish their Latin sufficiently to make a Latin edition of "Alice in Wonderland" commercially attractive to a modern publisher. Of course the sales record of that other Latin classic, "Winnie Ille Pu," may have been an encouragement to Macmillan's.

Latin is far from a dead language, and education boards ought to reserve an honored place for it in the curriculum. Not only is a knowledge of it essential to everyone who expects to understand the nuances of the English language, but it is the key to an exact knowledge of all of the Romance languages. As never before Americans are finding a knowledge of foreign languages essential. Those who acquired in high school and college the fundamentals of Latin discover that their lot is much easier when they are obliged to study a modern language intensively.

In the September issue of the "Publications of the Modern Language Association" Professor William Riley Parker of Indiana University has an essay, "The Case for Latin," in which he emphasizes the necessity of studying Latin, both as a cultural and as a utilitarian subject.

"Both government and the major foundations have done much in recent years to support modern foreign language study," Dr. Parker asserts. "It is time now for both government and the foundations to pay more attention to those solid, basic elements in the curriculum that do not have the additional advantage of sudden temporary relevance in our competition with Communism."

He urges the government and the foundations to do something to stimulate the further study of Latin because it is the basis of much other learning. Let us hope that they will heed Dr. Parker's warning that Latin must not be allowed to vanish from our curricula.—From *The Washington Post*, reprinted in *The Indianapolis Star*, Oct. 24, 1964.

It's Your Money

There must be many "Little Boy Blues" waiting to blow their horns in South Viet Nam.

The Defense Department is buying 3,900 bugles at a cost of $9.45 each for the Vietnamese forces.

"The department said they were to be used by military commands for charging, retreating, etc. The way things have been going, I fear they'll wear out the retreat end of the bugles first," comments Rep. William Minshall, R-Ohio—*Indianapolis News*, Nov. 4, 1964.

Report It, Doctors!

The great gray epidemic of venereal disease has become a public health crisis in Marion County. More of our children have had gonorrhea this year than measles—and this was an epidemic year for measles.

Public health authorities estimate there have been 6,000 cases of gonorrhea and 500 syphilis so far this year.

More than half of these victims are teenagers and a frightening number are school children. Syphilis and gonorrhea have become childhood diseases!

The epidemic is not a problem just of the slums. The authorities believe the emergency is as grave in the suburbs as it is in the inner city.

But the suburban eruptions have been dangerously concealed by physicians. An authoritative survey by the American Medical Association showed that Indiana physicians report to public health authorities only one of every 20 syphilis cases they treat and only one of every 49 gonorrhea cases.

This, despite a state law requiring physi-

cians to report venereal disease cases to health authorities. This reporting is imperative if the epidemic is to be checked.

The single case of gonorrhea that a private physician sees is only one link in a tragic chain of victims. If this link is reported to public health authorities they investigate to discover and treat the rest of the chain—the person who infected the victim and the persons the victim in turn infected. Reporting this single link may lead to the discovery and treatment of as many as several hundred more victims.

Because many physicians ignore these legal and moral obligations, literally thousands of the victims of this epidemic are left undiscovered and untreated in this county alone.

We urge—we would demand, had we the power—that physicians report these cases to the health authorities.

We urge this not because we expect that this will eliminate the social and moral causes of the great gray epidemic but to save the innocent—the boys and girls who will marry these hidden victims, the children these marriages will produce.

The great tragedy of this epidemic is that it was all so easily avoidable. *Indianapolis Star,* Oct. 4, 1964. ◄



From *The Journal* 50 Years Ago

. . . In this country there has been a noticeable tendency to consider both the teaching of neurology and psychiatry as special branches, rather than as intrinsic, basic parts of internal medicine, a thorough knowledge of which goes very far indeed toward solving some of the most intricate and difficult problems of internal disease, both organic and functional—so-called.

It can most truly be said that the greatest clinicians the world knows, or has ever known, had thorough knowledge of the physiology, normal and abnormal, of the nervous system as a whole and of its close relations to the physical-mental organism. In fact these same clinicians, who considered themselves as diagnosticians and internists, were often regarded by others, both fellow-physicians and laymen, as neurologists or psychiatrists or both, much to their disgust. Today, all neurologists and psychiatrists of note, are, strictly speaking, general diagnosticians, for they fully realize that all affections of the nervous system, whether accompanied by abnormal mental states or not, are problems of internal medicine, and oftimes surgery.

Every teacher of neurology and psychiatry emphasizes the importance of a clear understanding of this close relationship and constantly indicates the application of the principles of neurologic diagnostique and the clarifying power they bring into obscure problems of non-nervous origin. In this effort and direction neurologic and psychiatric instruction should continue to advance, for it is obviously impossible to attain anything like a well-rounded medical education without pretty thorough knowledge of the gross, and to a somewhat lesser degree, the finer, structures of the nervous system, the relation of its parts to each other and to the organism as a whole, its physiology, the principles underlying its normal manifestations and the mechanism whereby normal phenomena, physical and mental, are brought into play Albert E. Sterne, M.D. "The Teaching of Neurology and Psychiatry in Indiana," *JISMA,* December, 1914.



and it's not a once-over-lightly one, either. All rubber stoppers used in Lilly ampoules are scrupulously cleaned with a detergent and hot deionized water in a special washing machine like the one pictured above. This removes any foreign matter adhering to them. Then the stoppers are autoclaved at 120° to 121°C. for one hour. They are now clean, sterile, and ready for use. In case the stoppers are not used within seventy-two hours, they are returned for resterilization. □ This meticulous process is only one of the many safeguards to insure the quality of the finished product and to protect the ultimate user.

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The Journal
of the INDIANA STATE MEDICAL ASSOCIATION
Supervised by THE COUNCIL
Volume 57 — December 1964 — Number 12

The Current Surgical Approach to Otosclerosis

E. H. BERGENDAHL, M.D.
S. C. SNYDERMAN, M.D.
C. S. GIFFIN, M.D.
Fort Wayne

OTOSCLEROSIS ONCE WAS THOUGHT to exist in only about ten percent of the population; now the diagnosis seems to be made more frequently. One of the factors in this apparent increase is that something now can be done for otosclerosis. We feel that we can offer close to 90% improvement in the hearing of a patient with otosclerosis. Historically, surgery has been offered for this disease since 1878, by the technic of Kessel,[1] but maturation and refinement of middle ear surgery in recent years has progressed to the point where we can offer the patient a reasonably good chance of auditory gain.

Before proceeding, it would be well to review the mechanics of the hearing process. Sound waves strike the tympanic membrane, this energy is transmitted from the relatively large drum, via the ossicular chain, across the tympanum or middle ear to the oval window. The innermost segment of the ossicular chain, the stapes, sits snugly in the oval window and its piston-like motion is transmitted to the perilymphatic fluid immediately below its surface. The resulting motion of the fluid stimulates the nerve endings of the auditory nerve and these impulses are carried off toward the temporal lobe of the brain. Consequently, if there is a loss of energy due to the inability of the stapes to move freely, the patient will have a smaller stimulating effect on the perilymph with a subsequent loss of hearing.

Otosclerosis can be suspected by listening to the patient's history, inasmuch as there is a gradual onset of hearing loss. While this is the more common story, it may be brought to the patient's attention dramatically when he cannot hear well on the telephone or the family may suddenly be alerted by the increased volume used by the patient while watching television. While otosclerosis has been reported in children, it is not common in teenagers. The speed of progression of this disease is variable—in some cases it may be latent for periods of time and in others there may be rapid advancement with a concomitant severe hearing loss. It is also considered a familial disease but the number involved in any family varies.

Audiometric Testing

The ear, nose and throat examination is usually normal, but sometimes the drum may have a pink glow, known as Schwartze's sign. When this is present it is due to an increase in the vascularity on the medial wall of the middle ear, because of the activity of the otosclerotic process. In testing the hearing, it should be remembered that the process is one in which the stapes has poor mobility and a consequent poor conduction of sound across the middle

ear to the inner ear. Tuning fork tests and audiometric tests show the bone conduction considerably better than the air conduction, the former representing a direct stimulation of the auditory nerve.

For the ideal candidate, a patient should have a normal bone conduction and at least a 30DB air-bone gap. Not all practitioners, of course have audiometers in their office, but the purchase of good tuning forks of 256 or 512 double vibrations would be helpful in doing simple tests. If the patient can hear better with the fork held near the front of the ear, as compared to holding the base of the fork over the post-auricular region of the mastoid, this is considered normal and is called a positive Rinne test.

Obviously, if the reverse is true for otosclerosis, it should be pointed out that this is also true in conditions such as impacted cerumen, tympano-sclerosis, certain perforations of the tympanic membrane and chronic and acute infections of the middle ear. In addition to the above mentioned tests, we would also like to make further tests by which we attempt to determine the true function of the ear—that is—how well the patient understands the spoken word if sound is amplified.

Earlier Methods of Treatment

Otosclerosis is a process in which a deposit of new bone is layed down in the middle ear, most commonly in the region of the oval window. This reduces the motion of the stapes and clinically there is a loss of hearing. At the turn of the century, several men attempted to relieve this situation, primarily Miot and Jack by directly attacking the diseased site.[2,3] They approached this area by making an incision through the drum membrane and then removed the stapes. However, their work was not accepted with much enthusiasm by the otologic profession, due to the incidents of infection, deafness and meningitis.

Beginning with Holmgren of Sweden and Sourdille of France, the next efforts were to by-pass the diseased area and attempt a new means of transmitting sound to the perilymph by creating a window in the horizontal semi-circular canal, via a two-stage mastoidectomy.[4,5] This came to be known as the fenestration operation. Later in the 1930's, Julius Lempert[6] refined this approach with a one-stage procedure, giving us a great advancement in otologic surgery, because many of the technics he advocated were applicable for other surgeries of the ear and mastoid.

About ten years ago, Dr. Samuel Rosen reawakened interest in using a direct attack on the diseased site.[7] Rosen's first efforts were to gently exert pressure on the stapes and rock this bone loose to loosen the footplate inmeshed in the otosclerotic bone. This offered considerable appeal to the patients, because they could hear better and many of them could participate in aquatic activities relatively soon after surgery. However, there were certain drawbacks. Not everyone did well with this procedure, since it was not always possible to mobilize the stapes and sometimes the crura of the stapes were fractured with a subsequent greater loss of hearing. Where mobilization was successful there were cases where the stapes later became refixed. In all, only about 30% were benefited by mobilization.

Surgical Procedures

The current surgical technic used is as follows: With the aid of the operating ear microscope, which provides excellent lighting and makes possible enlargement of the operative field from six to 40 times, an incision is made in the canal in the posterior wall near the drum. The skin and drum are reflected forward to allow direct examination of the middle ear. This does not always allow for a complete view because the rim of the posterior canal wall is in the way and has to be removed either with an electric drill or a small bone curette. If it has not been visible before, the chordo-tympanie soon comes into view.

The ossicular chain is checked for its mobility and if it does not move well, the procedure can be continued. The stapedial tendon is cut and then the incudostapedial joint is severed. Subsequent to this, the superstructure of the stapes, consisting of the body and its two crura, are removed (Figure 1). When the small amount of bleeding is controlled, the footplate is removed, either by drilling a hole in its center

or cracking it and removing the pieces. At this point, gelfoam is put into the oval window as a vibrating membrane and a preformed stainless steel wire is crimped around the incus with its base resting on the gelfoam (Figure 2).

An alternative to this procedure, used in certain thick footplates, is that a hole is drilled through its center and a stainless steel piston (Figure 3) placed into this opening is then crimped around the incus.[8] Following this, the drum is rolled back to its original position and gelfoam with adrenalin is put over the incisional site. The type of dressing applied is optional.

We prefer to use a local anesthetic for the above precedure since it rarely takes more than an hour, usually less. It is thought too, that there is less bleeding in the middle ear when local anesthesia is used. The patient is hospitalized for a day or two following surgery and is seen in the office in approximately one week and again in two or three weeks. We also like to follow the patient in six months and one year, to see that his hearing is maintained.

During the past ten years, there have been many changes in the surgical technics for otosclerosis. We have suffered disappointments in stapes surgery to the same degree as those reported nationally. In addition to the technics mentioned above, we have tried and discarded the use of the pneumatic hammer to loosen the footplate, cracking the footplate and letting it stay in position, the use of the body and crura as a piston for the footplate, the fat prosthesis, the vein prosthesis with a polyethylene tube, etc. By the same token, we also feel more confident that the near 90% success we have obtained with the technic described above, utilizing stainless steel, makes it the operative procedure of choice.



FIGURE 1

STAPEDIAL FOOTPLATE with otosclerotic bone in the anterior portion. The incus projects over the footplate. The superstructure of the stapes, i.e. the crura and body have already been separated from the incus and removed.

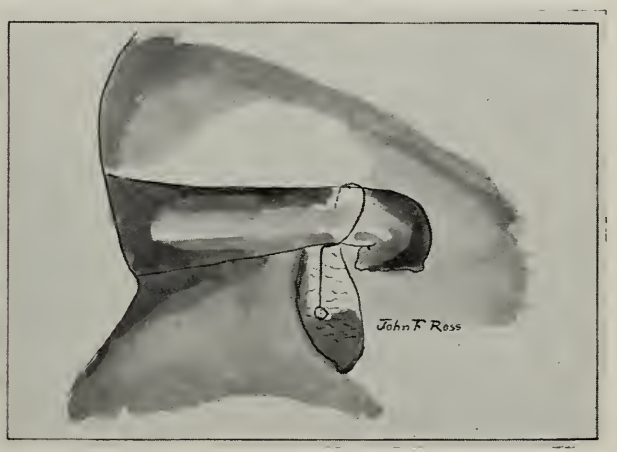


FIGURE 2

THE FOOTPLATE has also been removed and replaced by gelfoam. The pre-formed wire is crimped around the incus and rests on the gelfoam.

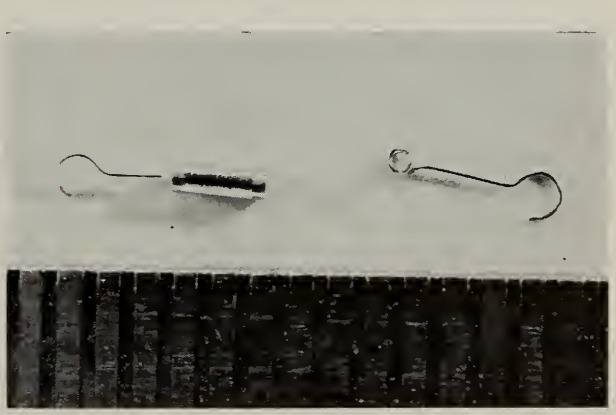


FIGURE 3

THE TWO TYPES of prostheses used are shown in comparison with a m.m. rule. Each dark line represents 1 m.m. The prosthesis on the left is the stainless steel piston used in thick extensive otosclerosis with a completely involved footplate. This piston was developed by Dr. M. McGee. The prosthesis on the right is the pre-formed wire used in the average case, developed by Dr. H. House.

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102 Medical Center Bldg.
Fort Wayne

Dr. Sadusk Urges Caution in Use Of Prescription Drugs

Physicians have a duty to their patients fully to inform themselves about the medicines they prescribe, Joseph F. Sadusk, Jr., M.D., Medical Director of the Food and Drug Administration, recently told the American Medical Association.

"Good and potent drugs continue to appear for your use," he told the nation's doctors at the AMA's annual convention in San Francisco, Calif. "But as the potency of these drugs increases, so generally does their complexity and their potentiality for harm. Consequently, it is your duty to fully inform yourself of the composition, mode of action, efficacy and potential toxicity of these agents before you embark upon their use. This information is readily available to you in all package inserts, in direct mailing pieces and in brief summary form even in the prescription drug advertising. You owe a duty to your patient to use this information."

* * * *

Dr. Sadusk noted that the relationship between the doctor and the FDA is a close one "and indeed, the relationship will grow closer as time goes along. The Congress, in the public interest, has charged the FDA with the responsibility of seeing that the profession is provided with effective and safe drugs for their patients and with adequate information for the safe and effective use of these drugs. The physician and the FDA have a mutual interest — and this carries with it a mutual responsibility — in the careful and judicious administration of medications," he said.

While the FDA can "to a certain extent" see that this is done, Dr. Sadusk said, "we must also depend upon the physician to apply these principles of balancing efficacy against toxicity at the individual patient level. The doctor must decide in light of a drug's potential toxicity, that its use is warranted for his patient."

Jejunogastric Intussusception Following Gastric Resection

HARLAN B. MOSS, M.D.
Indianapolis

JEJUNOGASTRIC INTUSSUSCEPTION following gastric surgery is a rare complication. There are, however, well over 100 cases reported in the literature. Most of these have occurred following gastroenterostomy, but in recent years more reports are appearing of intussusception following gastric resection.

The case presented here is reported in detail because the apparent rarity of the condition makes preoperative diagnosis difficult and because, with the number of gastric resections being done, it might occur more often than is recognized.

Case Report

A 51-year-old woman was admitted to Community Hospital, May 10, 1961, with complaints of weakness, occasional chest pain, swelling of the feet, stiffness of the ankles, difficulty in walking and alternating constipation and diarrhea.

She had had a partial gastrectomy in 1956 for an intractable duodenal ulcer. For a time after this operation she had felt fairly well, but in about six weeks, she began having a sensation of fullness after eating. Sweets made her "very ill." At the time of her operation in 1956 she had weighed 179 pounds, but upon admission to the hospital in 1961, her weight was 120 pounds.

Recently constipation had been severe and laxatives were ineffective. Before the onset of constipation, loose stools had been noted intermittently for years. For the past few months she had noted bright red blood in her stools which she attributed to hemorrhoids.

Physical examination revealed a thin, listless, pale woman appearing older than her 51 years. No abnormalities of the head, neck or chest were noted. Blood pressure was 125/75; heart rate was 76 per minute, rhythm was regular and no mumurs were heard. No rales were noted and the breasts were normal.

A lower abdominal midline scar (hysterectomy) was well-healed. A curved transverse epigastric scar was also present. There was questionable nodularity of the liver edge which was felt two centimeters below the right costal margin. No other masses were noted. The abdominal wall was quite thin. There was moderate tenderness in the epigastrium to the right of the midline.

Laboratory findings were startling. The hemoglobin level was 5.2 grams percent with a hematocrit of 22. The white blood cell count was 10,700 with a normal differential. A barium meal showed a large stomach pouch, and a colon x-ray revealed a constriction in the right transverse colon.

The radiologist thought that the constriction in the colon might be malignant, but the possibility of volvulus was also mentioned. After transfusion with five units of blood, an exploratory laparotomy was done on May 24. A large loop of transverse colon was found to be herniated through a defect in the omentum. Volvulus of the herniated loop produced the constriction noted on the x-ray. Correction of the volvulus, reduction of the hernia, and closure of the defect in the omentum were carried out, and many adhesions were taken down. Inspection of the stomach showed that a Billroth II antecolic anastomosis had been done by means of the Polya technic. There was no evidence of marginal ulceration.

Twenty-four hours postoperatively, blood came back through the nasogastric tube and the blood pressure fell. Transfusion of two units of stored blood had no effect on the hemorrhage, but after one unit of fresh blood was administered the bleeding stopped. A flat film of the abdomen showed some small bowel ileus and some free (postoperative) air in the peritoneal cavity. She



FIGURE 1
X-RAY of the stomach with dye surrounding loops of the jejunum.

continued to do poorly and did not eat well, complaining continuously of epigastric fullness.

A fluoroscopic study of the stomach was begun on June 7. An air bubble, interpreted as free air, was noted in the left upper quadrant. Gastrografin was placed in the nasogastric tube and was seen to surround two loops of small bowel in the left upper abdomen. The fluoroscopist immediately discontinued the examination thinking that the nasogastric tube lay free in the peritoneal cavity. There was, however, no clinical evidence of peritonitis (Figure 1).

With this information, believing that her debilitated condition had caused a lack of adequate response to gastrointestinal leak, she underwent surgery again on June 9, 15 days after her initial procedure.

At the second celiotomy, a large mass lay inside the gastric pouch. This felt very boggy, was not hard or nodular and proved to be a retrograde intussusception of the efferent jejunal segment into the stomach remnant. The intussuscepted portion of the bowel, measuring 20 centimeters in length, was necrotic. No leakage had occurred into the peritoneal space. There was no marginal ulceration.

The gastric stump and involved jejunum were re-resected and a Hofmeister type realignment was established. In addition a temporary tube gastrostomy was performed for stomach decompression in the postoperative period. She did well, leaving the hospital on June 18, 1961. A follow-up after

two years reveals that she has maintained her weight at 120 pounds, and she eats what she wants.

Comment

Retrograde intussusception of the jejunum into the stomach following gastric surgery is a very rare complication, but a treacherous one. It is difficult to diagnose with certainty because it is seldom suspected and because it may be intermittent. Even surgical exploration yields negative results at times.[2] In retrospect, fluoroscopic and x-ray studies in this case gave us the diagnosis, but we failed to recognize it. The hemorrhage 24 hours after the first operation probably heralded the onset of the intussusception.

Figure 2 indicates the appearance of the intussuscepted efferent portion of the jejunum at the time of the second operation. According to reports in the literature this type of intussusception is the most frequent (75%). Involvement of the afferent limb of the gastrojejunostomy occurs less often and prolapse of both limbs into the gastric pouch is rarer still.

The jejunum is actually turned inside out (Figure 2) with the valvulae conniventes contributing to the fanlike appearance (Figure 1) within the stomach remnant.

Jackman and Middlemiss have tried to set up a classification of retrograde intussusception according to its onset, persistence and severity.[2] Using their criteria, this case would be called acutely delayed, but the possibility that she had had repeated bouts of reducible intussusception over the years since the gastric resection cannot be denied. An x-ray of the stomach taken shortly after admission showed no intussusception. This does not rule out the possibility of the chronic recurrent form.

The herniation of redundant transverse colon through a hole in the omentum in this case has to be classified as iatrogenic. The freeing of adhesions at the time of the first exploration probably allowed enough mobility of the jejunum to lead to irreducible intussusception.

The ultimate cause for retrograde intussusception is not known, but the size of the postoperative opening in the stomach apparently has something to do with this abnormality.[7] Most of the cases reported are either in gastroenterostomy patients or are in cases of resection with Polya reconstruction.[1,3,4,6] The Hofmeister technic with its smaller gastric outlet seems to hinder the onset of this particular complication.

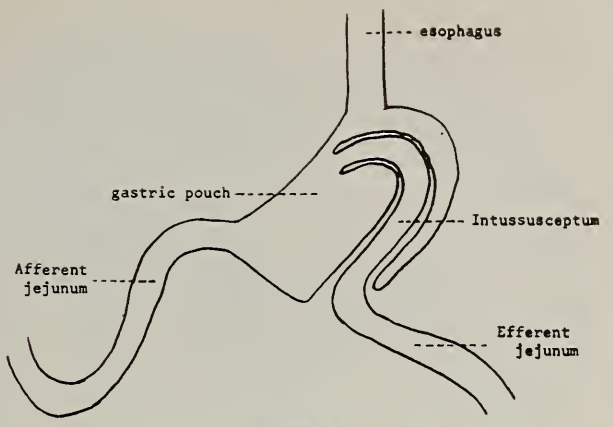


FIGURE 2
DIAGRAM showing prolapse of the efferent limb of the jejunum.

Although some authors contend otherwise, there is apparently no connection between vagectomy and the development of jejunogastric intussusception. The role of vomiting in the condition is not clear. Some authorities think that the increased pressure in the stomach with vomiting tends to reduce or prevent intussusception. Others believe that vomiting, with the sudden retograde expulsion of stomach contents, acts to draw the jejunum toward the esophagus —to expel the jejunum from the stomach along with the rest of its contents.

A recent report in the surgical literature cites an instance in which straining at stool precipitated a jejunogastric intussusception.[5] This may indicate that increase in intra-abdominal pressure from any cause—vomiting, straining, lifting, external force—might play an important role in the production of retrograde intussusception.

There is also no adequate explanation for the more frequent occurrence of retrograde intussusception following gastroenterostomy rather than following gastric resection.[3] The ratio is reported at 13 to 1. Perhaps this ratio will become much less in the next few years when the impact of the popularity of gastric resection in the 1950's begins to be felt. In fact there are upwards of a dozen cases listed in the cumulative index of the world's medical literature for 1962.

In most of the reports of retrograde intussusception following partial gastrectomy, the Polya type of realignment has been followed. This points to a wide gastric opening as contributing to the development of this condition.

Cases are cited in the literature in which the intussusception corrects itself without operative interference.[2] Barium studies sometimes result in spontaneous reduction. Changes in position from horizontal to upright during fluoroscopy also cause reduction of the prolapse on occasion.[6] In the case presented here it is probably fortunate that reduction of the necrotic segment did not occur. It is possible that the necrotic jejunal intussusceptum, if left in place, might be digested by the stomach secretions and the obstruction ultimately relieved. This is a dangerously optimistic hope and is not recommended. Re-operation is the safer course to follow.

Summary

An infrequent complication of gastric surgery is reported. Intussusception of the jejunum into the stomach follows gastroenterostomy or Billroth II gastric resection. Although the exact cause is unknown, its development is apparently dependent upon the construction of a large opening in the stomach. The Hofmeister type of resection hinders the evolution of this complication. The Billroth I resection precludes it.

The rarity of the abnormality makes preoperative diagnosis difficult. The condition should be suspected in any patient with a history of gastric surgery whose signs and symptoms point to a high small bowel obstruction.

The literature contains several cases in which the condition is intermittent—inconvenient, but not incapacitating. Irreducible intussusception, as in this report, is a surgical emergency.

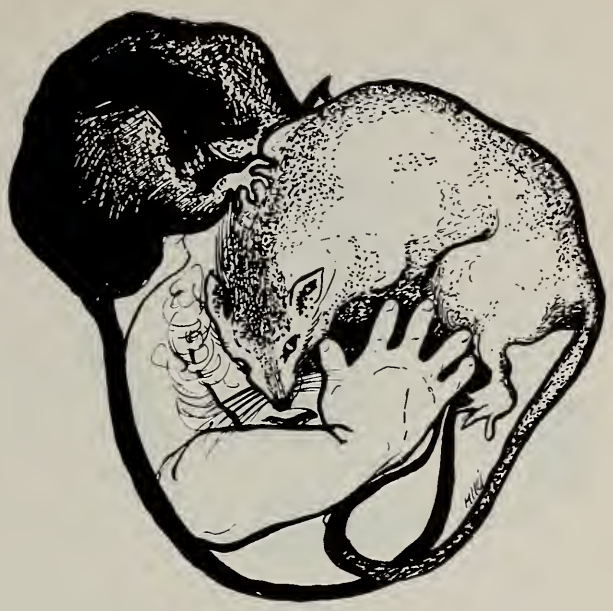
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The Case of the Rampaging Ravenous Rodents

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EVEN IN WEALTHY New York City, the poor are always with us. The seamy side of life fosters bad public relations — "hot, steaming summers" — and it can be embarrassing. A family had been destroyed in a rather other than ordinary manner. A week after the event, I saw an item mentioning a particular tenement. A couple of residents at a municipal hospital did learn from the occurrence, and I do think the case deserves more than just a passing, prettified report.

Apropos many things, — let us mention briefly the largest order of mammals, viz., the rodents. By definition, these are all *gnawing* creatures with perpetually growing, self-sharpening, chisel-like, incisor teeth, compartmentalized in a projecting, swiveling snout. Curiously, rabbits and hares comprise a closely related but separate order.

There are more than 6,000 kinds of rodents; in actual combined mass they exceed the combined total of all other mammals alive on the earth today! The largest are the capybaras of South America; they are harmless grass eaters reaching a length of four feet and weighing as much as 100 lbs. At the other end of the scale are the tiny field mice: weight, a few grams; length a few cms . . . Yet, by sheer, prolific numbers, their ravenous appetites deplete harvests everywhere. We'll only mention in passing the porcupines, beavers, chipmunks and squirrels (of course, these too are all rodents).

But — of utmost importance to our tale — we have RATS!! Not only muskrats and such but the true rat: 550 recognized members of the family, Rattus. Formidable, detested camp-followers; since pre-history, they have harried mankind all over the world. These vermin thrive on filth and squalor; they feed on anything edible; even each other if need be. The "average" common rat, *Rattus norvegicus*, weighs a pound or two; giants can be a foot long and weigh four pounds: a fearsome sight, indeed! Having made these preliminary remarks, let us proceed to the events as they actually unfolded.

"Bit the Babies in the Cradles"

Not too many months ago, the pediatricians asked me to see immediately a just admitted emergency. The request was unusual and so couched that I went forthwith. An 8-month-old infant was lying in the tiny crib. A couple of residents were trying to stanch the blood gushing from the remnants of a face! The entire nose, left eye, cheek and chin had been gnawed down to the bone by a rat that had invaded the crib even as the mother had been busying herself in the adjoining kitchen. . . .

What could I do or say? Mercifully, even while the parents waited numbly outside, the baby passed out of its misery. The



mother started to weep hysterically; the father arose and strode out silently. Later, I heard that he had gotten himself blind drunk; while staggering across the road against the light, a car had struck and killed him. Or: had he wanted it that way?

Next day, the papers chronicled both items most briefly. The injuries sustained by the child were unspecified. To its credit, let it be said, even the yellow press has some fleeting inhibitions!

Some ten days after the episode, the resident and I strolled into the female ward to see an unconscious woman just admitted. She was neatly garbed, immaculately clean: a very lightly colored, really beautiful, quite young woman. She was almost in a coma being unresponsive to questioning but wincing when stimulated painfully. A careful physical examination in the emergency room had revealed a temp. of 101° F, heart rate of 110, blood pressure of 120/70. The heart and lungs were unremarkable and the abdomen was unrevealing. The reflexes seemed normal even if there was a hint of nuchal rigidity. The definitive diagnosis of coma is not always a simple matter.* The intern had joined us: the doctors were preparing to draw the usual blood and urine specimens. Also, the spinal puncture tray was called for.

As I was standing at the foot of the bed, I looked at the card with the patient's name. As a rule, my memory for names is pathologically bad; faces, I do remember. Somewhere, recently, I had seen this woman. Then, I looked at the name and address again; sudden recognition rang a jangle of bells! This was the mother of that rat-gnawed infant! What had brought *her* to the ward? Had she taken anything?

"Rouse Up Sirs!
Give Your Brains a Racking . . ."

I scanned the face with meticulous, professional alertness. The pupils and eye-grounds were perfectly normal but — what were those irritated looking marks on the bridge of the nose? Friction from eyeglasses? Bridge too tight? The rest of the face was unblemished; these lesions just *looked* different. In my pocket was the little loupe we all use when scanning EKG's; wiping it clean, I peered curiously at the wounds. Of course, my awareness of WHO the patient was had alerted me. I had not shared, as yet, this knowledge with the resident staff; I could sense the perplexity with which they watched me going through the maneuver made so famous by Sherlock Holmes. What I saw convinced me!

"Ah, there, gentlemen: I did not mean to pique your curiosity. However, if you will look for yourselves, unless I am completely at fault, we are dealing with a case of more than usual interest and pathos. These are BITE marks! This woman must have been attacked by some animal while she was asleep in bed. The fangs of a snake *could* have done this. In our teeming metropolis, we do not encounter many rattlers (or such) prowling in the thatches of cabins. However, we do have a terribly *vicious, ravenous, rampant rodent* that nests in the walls and floors of many of our buildings: dilapidated tenements, in particular. It is my opinion that we are looking at a RAT bite at least a week old that has begun to fester!"

While I was discoursing, my doctors were looking with fascinated interest at where the rat had snapped its incisors together. "Now, men! the wharf rat goes by many names that only confuse. We should be aware of TWO diseases it can transmit to man. One is sodoku fever: Japanese for rat — *so* and poison — *doku;* very appropri-

* Case of the Digressive, Diagnostic Diablerie, *JISMA*, 56:12, Dec., 1963, pp. 1518-1521.

ately translated as rat-bite fever. The other disease is Haverhill fever which was first recognized as a separate entity in the Massachusetts city of that name.

"Sodoku is due to the Spirillus minus; the other, due to Streptobacillus moniliformis. Again, these pathogens have been called many things; don't let that confuse you either. The rats live in practical symbiosis with these organisms; they cause fairly serious diseases in humans unfortunate enough to be bitten by these vicious vermin. I suggest that you draw blood cultures and ask specifically for them to be searched for these rather — shall we say, unusual — organisms."

"But, sir! We have never heard of rat-bite fever being a cause of coma!"

"Well, neither have I; Heaven knows, I'm lucky enough *not* to have had much experience in this field. I do know that Cecil-Loeb (11th ed. pp. 371-373) has an excellent summary on this. Also, I had occasion to look at a book published by Charles C Thomas *Diseases Transmitted by Animals to Man,* (5th ed., Thomas G. Hull, Ph.D., pp. 652-667) on the same topic.

"To See the Townsfolk Suffer So"

"Now, as to the deep stupor: well, the bite is definitely in the middle third of the face. It drains through the orbits directly to the brain. Before the days of sulfa and penicillin, we were cautioned ever so emphatically not to squeeze upper lip or nasal pimples just for that reason."

The spinal puncture did show a moderate increase in pressure; the Pandy test was two plus, the cell count was only 15, mostly lymphocytes; protein content was up as was the sugar. All this was consistent with, but not proof of, an encephalitis. Some streptobacilli were grown out but the laboratory mumbled about "contamination." A survey of the literature is barren of any references to rat-bite meningoencephalitis.* Our case could have been a very first instance of central nervous system involvement by rat-bite fever pathogens. Obviously, we did not obtain proof positive.



Immediately after drawing the blood specimens, the woman was put on massive penicillin therapy. Maybe for that reason, the patient never did develop the meticulously described macular rash. Regional glands were inside the skull so that they could not be seen or palpated. The fever receded promptly — nay, dramatically. The stupor vanished by the second day. The cultures showed copious quantities of both the spirilla and the streptobacilli: there was no shadow of doubt about THAT! By the fourth day, the patient was well enough to get out of bed and start taking care of herself. No further anti-rat-bite fever medication was necessary.

"And out of the Houses the Rats Came Tumbling"

There is a postscript to the narrative. A couple of reporters got together and wrote some brutally plain stories about the city's rat population. The building inspectors huddled with the Board of Health people; a rather dangerous experiment was performed. That particular tenement was evacuated of its human population for a couple of days (room was provided by a nearby housing project and some hotels). KCN gas was used after the entire building

*The archive library department of the AMA aided our search. Mrs. J. S. Brown sent us photostats of much literature on rat-bite fever. She failed, also, to find anything on the CNS involvement.

had been rendered air-tight. After all, that is the method used to fumigate ships, docks and wharfs; the *only* enormous danger lies in the fact that some child might get into the building while it is being permeated by the deadly fumes of cyanic acid that does not differentiate between human lungs and the lungs of rats or roaches.

The operation proved completely successful; rather tentatively and without undue publicity, it is being repeated in certain other heavily rat-infested tenements. Next to having the Pied Piper of Hamlin available (I question his ability to entice sophisticated CITY rats), this is proving rather satisfactory — so far.

Since the above described events, there has just taken place a truly sensational discovery that proves again the enormity of our essential ignorance. While searching for an anti-inflammatory agent, biochemists synthesized *norborene,* a hitherto nonexistent compound. In preliminary tests on animals, the experimenters were astounded to learn that rats, and rats only, were quickly killed by this drug: Repeated testing has apparently confirmed this baffling phenomenon. Now, it has been relabeled *RATICATE* and is being tested in the field.

The torture undergone by the family we have just discussed may not have been altogether in vain. "The Lord moves in mysterious ways his wonders to perform. . . ." ◄

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Death by Default

The public must be protected of course, but isn't there such a thing as over-protection? Certainly it is no problem to prevent the introduction of any drugs with potentially harmful or mildly harmful side-effects.

It's simple — just don't develop any new drugs, or at least make it very difficult for a new drug to be tested and/or marketed. The only difficulty here is that many lives and the improved health of many others would be lost by default, that is, drugs that could be of benefit would never be developed.

This is just as wrong as allowing anything and everything to be pushed onto the drug market. For the non-medically orientated, it is quite easy to understand the sad results of a thalidomide deformed baby but far less easy for many to comprehend the equally sad results of those lives that can be lost by default. — Joseph P. Schaefer, M.D., in *New Physician,* 13:10, (Oct.), 1964.

Electrocardiogram of the month



Presented as a regular feature of The JOURNAL, Electrocardiogram of the Month is a series of short talks on cardiovascular diagnosis and treatment, edited by the staff of the Krannert Heart Research Institute, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis.

Vagal and Extravagal Effect Of Digitalis in Atrial Fibrillation

CHARLES FISCH, M.D.
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DIGITALIS exerts a vagal and extravagal (direct myocardial) depressing effect on atrioventricular (A-V) conduction. It is through this dual mechanism that glycosides slow the ventricular response in cases of atrial fibrillation (A.F.). If the slowing of the ventricles is due simply to the vagal effect, exercise or atropine, the ventricular rate will increase by abolishing this action. One of the true honored signs of full digitalization has been slowing of the heart rate so that the ventricular rate would increase very little upon administration of atropine or with exercise.

Furthermore, one of the criteria of overdosage has been the appearance of a slow, regular ventricular rhythm secondary to heart block due to digitalis. It is interesting therefore, to present an example of a slow, regular ventricular response in an instance of A.F. which not only was not due to digitalis depression, but also upon mild exercise, increased markedly the ventricular rate indicating need for more digitalis (Figure 1).

Row 1 in Figure 1 shows A.F. with runs of slow (about 43 beats per minute) and regular ventricular response usually indicative of digitalis overdosage. On minimal exercise (five sit ups in bed) the ventricular response rose to approximately 180 per minute. After the exercise was stopped, the rate slowed gradually over the next five minutes. ◄

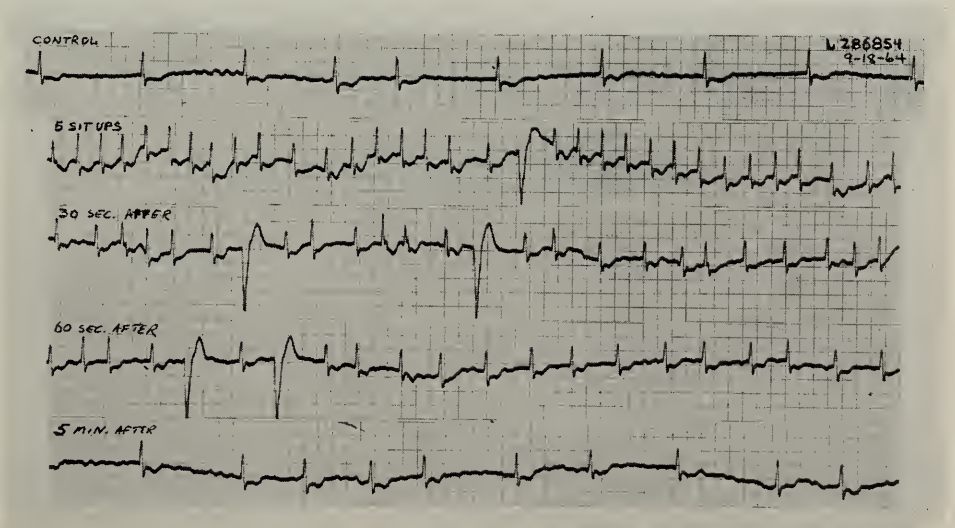


FIGURE 1
THIS FIGURE shows the slow, regular ventricular rate with a prompt response to minimal exercise. (For details see text).

X-RAY CONFERENCE

Presented as a regular feature of *The Journal*, X-ray Conference is a series of short talks on procedure and radiologic diagnosis, edited by Erich K. Lang, M.D.

Herniation of the Bladder into A Right Femoral Hernia

*ERICH K. LANG, M.D.**
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A 72-year-old white male was admitted to Methodist Hospital for repair of a right femoral hernia. The patient had noted a mass in the right groin with gradual enlargement over the past two years. The striking observation of cyclical increase and decrease in the size of this mass in the course of each day was particularly emphasized in the history. The patient was aware that the mass would decrease in size after urination and that it would disappear almost completely if urination was accompanied by external pressure against the mass.

Physical examination revealed a firm grapefruit size mass inferior to the femoral triangle. Fluctuation was readily observed, however there was no tympanitic response to percussion. The mass could be readily reduced by extrinsic pressure. The typical defect of a femoral hernia was readily palpated.

An intravenous pyelogram revealed normal upper urinary tracts, however the bladder showed a "dumb-bell" configuration, with more than one-half extending into the hernia sac (Figure 1). A cystogram confirmed that more than one-half of the bladder had herniated through the defect and protruded into the right groin as typical content of a femoral hernia. Voiding effort without extrinsic compression of the herniated component of the bladder failed to empty the contrast medium from the component. However, when extrinsic pressure was applied against the hernia sac, complete emptying was observed.

Discussion

The contents of femoral hernias are usually small or large bowel loops. Other abdominal organs or intraperitoneal organs rarely herniate into the hernia sac. Ovaries, tubes, ureters, seminal vessels and portions of the bladder have been found in these hernias. The appearance and manifestation of herniation of the bladder into a femoral or direct or indirect inguinal hernia are quite characteristic. The hernia does not show any tympanitic characteristics and can be readily reduced by manual compression in association with voiding. A cystogram will readily and definitively demonstrate the abnormality. Recognition of herniation of bladder into a hernia is of utmost importance since proper replacement and fixation of the bladder during and after the herniorraphy is of utmost importance.◀

* Radiologist, Methodist Hospital.

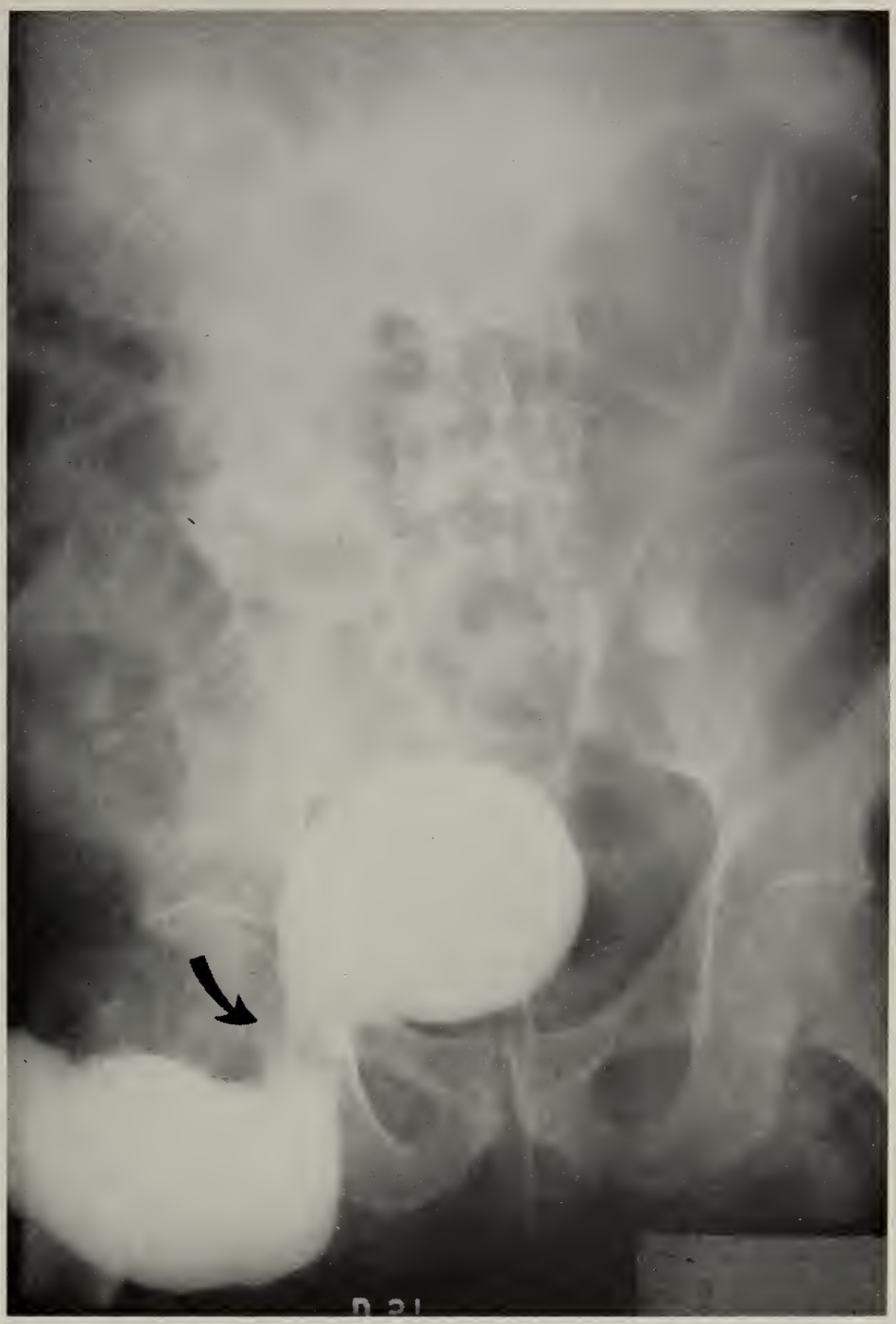


FIGURE 1
NOTE THE TYPICAL "dumb-bell" shape herniation of more than half of the bladder through the hernia ring into a direct femoral hernia sac.

LABORATORY MEDICINE

This page reviews established or relatively new but reliable laboratory procedures for physicians in general. It is not designed for specialists and laboratory personnel who would desire more technical information.

Serologic Tests for Syphilis (Part 11)

WEI-PING LOH, M.D.*
Gary

Biologic False Positive Reaction (BFP)

The prevalence of BFP is well known and deserves further discussion. It is estimated that approximately two percent of the estimated 2,400,000 STS-reactive cases in this country today are BFP cases.[11]** Stokes, in 1934, enumerated about 30 conditions that rendered frequent, occasional or disputed BFP reactions.[13] Moore, in 1952, listed the following conditions responsible for BFP[1]:

	Condition		*Approximate Percentage Incidence of BFP Reactions*
A.	Infections:		
	Bacterial	Leprosy	60
		Tuberculosis, advanced	3-5
		Pneumonia pneumococcal	2-5
		Subacute bacterial endocarditis	5
		Chancroid	5
		Scarlatina	5
	Spirochetal:	Leptospirosis	10
		Relapsing fever	30
		Rat-bite fever	20
	Plasmodial:	Malaria	100
	Rickettsial:	Typhus	20
	Protozoal:	Trypanosomiasis	10
	Viral:	Vaccinia	20
		Pneumonia, "atypical"	20
		Measles	5
		Chickenpox	5
		Lymphogranuloma venereum	20
		Infectious hepatitis	10
		Infectious mononucleosis	20
		Common cold	? low

* Chief Pathologist, Methodist Hospital of Gary; Assistant Professor of Pathology, Chicago Medical School.

** Dr. Loh's footnotes appeared in Part 1 of this article, Nov., 1964, p. 1255-56.

B. Non-infectious conditions:

Lupus erythematosus (disseminated or discoid)	20
Rheumatoid arthritis	5
Blood loss, repeated (as in multiple donations for transfusion)	? low
Pregnancy	? low

(Also included in this category are hepatocellular damage and autoimmune disease)

Other conditions known to give BFP reactions include yaws, pinta, vaccination reaction, malignancy and collagen diseases. In fact, any metabolic disturbance or febrile episode in supposedly normal individuals may at times cause BFP reactions. It is estimated that about 20% of the normal adult population may be potential BFP reactors under appropriate stimulus.[1] Moore[1] divided the BFP reactions into acute reactions persisting less than six months, and chronic reactions lasting for years or even a lifetime. Of special interest is the statement[8] that BFP reactions were noticed in 10% of the patients who took hydralazine hydrochloride (Apresoline) for prolonged periods, the average patient taking 600 mg. or more of the drug daily over an average of 12 months or longer. It is also stated that BFP reactions may occur one or more years prior to the development of recognizable lupus erythematosus or rheumatoid arthritis.

All of the BFP reactions thus far mentioned are blood reactions. False BFP reactions in the spinal fluid do not occur except in certain early recognized neurological disorders.[1]

A Few Rules to Follow

While patients should be handled on an individual basis and rules of any type for requesting serologic tests are only to be condemned, it is always practical to suggest a few rules for physicians who may not know too much about the serologic tests.

1. All blood specimens for diagnostic testing should first be subjected to a standard test for syphilis (STS) using nontreponemal antigen.

2. All test results should be correlated with history and clinical findings.

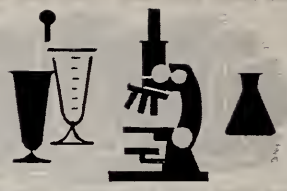
3. If the initial STS is non-reactive and clinically there is no evidence of syphilis, active syphilis is practically excluded.

4. If the initial STS is reactive,
 a) perform a quantitative standard nontreponemal test such as VDRL or Mazzini, and
 b) repeat the test on a second blood specimen.

 Reactive results verified on a second specimen (especially with rising antibody titer) in patients in whom clinical and/or epidemiologic evidence does not oppose the diagnosis means syphilis with a high degree of reliability.

5. If the initial STS and the subsequent STS are persistently reactive, perform a treponemal test — KRP or FTA — in order to differentiate between syphilis and BFP.
 a) If the KRP or FTA is reactive, the test results would indicate syphilis present or past with as much reliability as serologic testing affords.
 b) If the KRP or FTA is non-reactive, the patient should be tested further with TPI (if early syphilis has been excluded). If TPI is non-reactive, the patient probably has BFP. If TPI is reactive, the patient has syphilis with a high degree of reliability. It is hoped that the new FTA-ABS procedure will eliminate the need for TPI testing, which is expensive and technically complicated. ◄

Path-finder
PUBLISHED UNDER THE AUSPICES OF THE INDIANA ASSOCIATION OF PATHOLOGISTS



An Evaluation of a Slide Test for Pregnancy

J. THOMAS BENSON, M.D.*
Indianapolis

THE DIAGNOSIS of early pregnancy by the demonstration of excreted chorionic gonadotropins in the urine has passed from a phase of biologic testing utilizing various animal species to more simple in vitro immunologic tests that can be performed with a minimum of equipment in a very short time. These tests utilize human chorionic gonadotropin (HCG) antiserum and HCG-coated particles in a variety of serologic systems.

Since the test materials are now commercially available in kit form standardized by the manufacturer, the feasibility of their use in the clinician's office practice appears likely. To be effective for general office practice, any such test must be acceptably accurate and capable of being performed by a worker relatively unskilled in laboratory technics. To evaluate the latter criterion, results obtained by interns, residents, and nurses performing the test have been compared with the results obtained by an experienced laboratory technician utilizing the same urine specimens.

Principles

The serologic test chosen for this trial was an agglutination-inhibition test† which is performed on a glass slide and can be interpreted within a few minutes. The term "agglutination-inhibition" accurately describes the positive end result when a urine specimen containing a quantity of gonadotropin sufficient to indicate its production by placental tissue neutralizes the HCG antiserum and prevents agglutination of a suspension of HCG-coated particles. Thus, when a patient is pregnant, sufficient urinary chorionic gonadotropin is present to inhibit the agglutination that would occur were the gonadotropin absent and the HCG-coated antigen particles were allowed to be agglutinated by the HCG antiserum.

In actual practice, a drop of urine from a random specimen is mixed with a drop of HCG antiserum on the glass slide. After thorough mixing, two drops of HCG-coated latex particles are added and mixed. The neutralization of the antiserum must precede the addition of the antigen suspension. The *absence* of agglutination is the *positive* result. The presence of agglutination is a negative result.

Materials and Method

Fifty-five patients seen in the obstetric and gynecologic out-patient clinics of Methodist Hospital were chosen as test cases. Twenty-seven of these were clinically known to be pregnant (in the 42-92 day period following the last menstrual period) and 28 nonpregnant. Urine specimens collected at the time of the clinic visit were tested by members of the intern-resident house staff and nurses working in the department. The same urine specimens (from 25 of the patients) were then submitted to the pathology laboratory where the same test and an additional in vitro serologic test** were performed with no knowledge

* From the Department of Obstetrics and Gynecology, Methodist Hospital Graduate Medical Center.

† Gravindex, Ortho Pharmaceutical Corp., Raritan, New Jersey.

** UCG Test — Wampole Laboratories, Stamford, Connecticut.

as to the clinical status of the patient or results of the previous test.

Results

All tests performed by the experienced laboratory technicians proved accurate as to the diagnosis of the presence or absence of pregnancy. This group included three cases in which errors in performance or interpretation were made by the doctors or nurses. In the entire series of 55 patients, five errors resulted in the interpretation of the test by the doctors and nurses, producing a 91% overall accuracy. Three incorrect interpretations were falsely positive and two falsely negative.

Tyler et al.[1] report that 98% of urine specimens examined 42-92 days following the last menstrual period were accurately diagnosed, although urines tested earlier than 42 days were generally unreliable. Noto,[2] in a comparative study, reported 97% accuracy in 171 tests. Henry et al.,[3] performing 188 tests, found no false-positives and found that most false-negatives were from patients with very early pregnancies (five weeks following the last menstrual period) or missed abortions. Other experience[4] has likewise indicated adequate accuracy of the test when performed by experienced personnel.

Conclusions

A simple immunologic slide test for the diagnosis of pregnancy has been reliable in the hands of experienced laboratory technicians. It proved to be 91% accurate in the hands of doctors and nurses who were relatively untrained in laboratory skills and had minimal experience in the interpretation of agglutination tests. Technical errors could occur from: (1) improper sequence of mixing reagents, (2) mixing ingredients too vigorously, (3) drying of the test mixture, (4) incorrect interpretation as to whether or not agglutination has occurred and (5) misunderstanding of the meaning of the result.

The test would be adaptable to clinical office use only if the person performing and interpreting the test is first trained for this purpose, and then maintains his ability with sufficient work load and continued performance of the test.

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The Journal
of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

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Do You Have A Hemophiliac Patient?

THE INDIANA state chapter of the National Hemophilia Foundation, 926 N. Oxford St., Indianapolis, has announced the formation of a Medical Advisory Council. The members of the council are: Dr. Lee Foster, pathologist; Dr. Jon Herrold, oral surgeon; Dr. Carl Martz, orthopedic surgeon; Dr. Robert Rohn, hematologist; and Dr. Gabriel Rosenberg, pediatrician. Dr. Foster is serving as chairman of the council for this year.

As part of its function of providing guidance to the chapter and information to doctors, the council is attempting to set up a centralized statewide registry of hemophiliacs. At present the chapter has data on only a fraction (20%) of the state's several hundred hemophiliacs. Other chapters of the hemophilia foundation have found hundreds of hemophiliacs who were unaware of the existence of the Hemophilia Foundation and the services it offers. Information about names, addresses, ages and type of hemophilia is solicited from medical practitioners around the state and should be sent to S. T. Friedman, secretary of the Medical Advisory Council, 3946 Washington Blvd., Indianapolis, Indiana 46205.

The Indiana chapter is one of 41 chapters of the National Hemophilia Foundation. Founded in 1948, the national organization registers and issues identity tags, raises funds for research, develops and improves therapy, disseminates information to families of hemophiliacs, physicians and the general public. The chapters maintain frozen plasma blood banks and plasma depots in hospitals and support a number of diagnostic, dental and orthopedic clinics for hemophiliacs. Thanks to advances in hematology, the efforts of the National Foundation and hemophilia societies in other countries, a nearly normal life is now possible for hemophiliacs receiving up-to-date care.

Single Transfusions Unnecessary?

THERE is a tendency to classify all "one-transfusion therapy" as unnecessary. A "ruling" has been proposed to the effect that a patient who has received only one 500 ml unit of blood did not really need a transfusion and should not have received any blood.

This is about as rational as saying that a patient who has received five units of blood should always be given a sixth unit.

Five hundred ml of blood has constituted a standard transfusion unit for many years, probably for as long as blood transfusion has been a recognized form of therapy. The size of the unit was probably determined by estimating how much blood a healthy donor could part with without unusual risk.

If 500 ml of blood is the average amount a healthy adult can do without, it must, by analogy, be a sufficient amount in some instances to salvage a depleted patient and produce the difference between life and death or between prompt recovery and a lingering convalescence.

If a patient who can lose 500 ml of blood without danger suffers a state of shock from the loss of 800 ml of blood, one 500 ml transfusion will restore him to safety.

One effect of the new "rule", if it is adhered to, will be to influence physicians to procrastinate until the patient requires 1,000 ml of blood before starting the first transfusion.

While it is freely admitted that single transfusions are sometimes given when the patient would have survived without any blood, it must also be recorded that one transfusion unit, if given promptly and on valid indications, will often resuscitate a patient, who if not treated promptly, would deteriorate to the point at which several transfusions would be necessary.

It may be that the rule "if you do not need 1,000 ml of blood you do not need any" is a good device by which a medical record inspector may arrive at recordable conclusions as to medical practice. However, it is preferable to honor the judgment of the physician who is at the patient's side when the decision is made. He is the one who bears the responsibility for the consequences. He is the one who has seen patients in extremis returned to a state of good prognosis with the administration of one unit of blood.

It is encouraging to note that the Committee on Blood of the American Medical Association has recognized the dangers of the "two transfusions or none at all" rule and has advised that physicians should not be compelled to administer two units of blood if one unit does the job. "The committee recognizes that in indicated situations, the transfusion of a single unit of blood reflects sound judgment and is in keeping with good medical practice."

Blood transfusions should be used only when indicated and only in the amount indicated. Giving two units where one has been effective doubles the risk of the transfusion without doubling its good effects.

The Pharmacy as a Health Education Center

THE ABILITY of a retail pharmacy to function as a disseminator of health education information has just been investigated by a nation-wide study conducted for the American Pharmaceutical Association and the U. S. Public Health Service by National Analysts, Inc.

Eighty-five different health information pamphlets were contributed in 50,000 quantities by each of 26 national voluntary health agencies. A total of 4.3 million pamphlets were utilized.

Two hundred and forty volunteer pharmacists were selected in October, 1963, in such a way as to make a country-wide representation. Five randomly selected prescription patrons from each pharmacy were interviewed before the health pamphlets were displayed.

During November, 1963, each pharmacy received a display rack of health pamphlets. These racks were placed near the prescription counter and customers were invited to read the booklets at the store or to take them home. The displays were restocked with a succession of various pamphlets each month until April, 1964.

At the end of the six-month health literature display, 1,200 patrons were again selected at random and interviewed. Each of the participating pharmacists also was interviewed at the conclusion of the experiment.

The object of the study was to determine the changes in attitudes, opinions and behaviors of patrons as a result of the display of health information booklets and to determine the amount of participation on the part of the pharmacist in promoting the distribution of the printed material.

It was found that of the original interviewees, 10% said they had seen the dis-

play rack (there had been comparable displays previously in some of the participating pharmacies). At the final interview, 42% of the people reported having seen the display. Country-wide, a greater proportion of the ones who remembered seeing the display were from the central part of the U. S., were younger than 45 and were female. The more education the interviewee had, the more likely he or she was to have seen the display.

When it is considered that there are many attractive displays in pharmacies and that 42% of the people interviewed remembered seeing the display, and when it is learned that almost exactly two-thirds of all who saw the pamphlet rack took and read at least one of the pamphlets, it is evident that the health information material received attention and a significant amount of it.

When queried as to whom the interviewee considered as a source for health information, almost every one listed the physician as first choice. Seventy-two percent indicated the pharmacist as second choice in the preliminary interview and 75% in the final questioning. The three most popular topics for discussion with the pharmacist were respiratory diseases, skin care and prescription medication.

The three most popular pieces of literature taken from the display racks dealt with heart diseases, cancer and arthritis, although respiratory diseases, children's diseases and mental disease were almost as often studied.

The study demonstrated further that the patrons who actually remembered seeing the display were more apt to consult the pharmacist on health matters. Those who took the pamphlets were a little more apt to consult him and those who took the pamphlets home, even more so. Even though pharmacists reported that they usually called attention to the display more often in the case of lesser educated people, the ones with the higher education were affected more favorably by the literature displayed.

The overall conclusion was that the method was highly effective in bringing good health information to the patrons of pharmacies, and that with slight improvements in the display and with more active participation by the pharmacists, the results would be even better.

Many of the members of allied health professions were attracted to the pamphlet racks and commented favorably. Most pharmacists felt that the program produced a better image for the pharmacy and increased the contacts of the pharmacist with his patrons on a service-oriented level.

Guest Editorials

Frozen Food for Hospitals

A REPORT by B. S. Platt and his colleagues last year[1] noted that the larger the hospital the lower was the efficiency of administration and the quality of food as served. Yet, as a leading article in these columns noted,[2] the small hospital is precisely the type due to be abolished and replaced by large district hospitals. The report suggested, as others have done, [3,4] that it would be possible to retain the virtues of the best small hospitals by the cooking, packing and deep-freezing of meals in food factories. The meals could then be distributed to small ward kitchens for a final rapid heating immediately before being served to the patients.

The production of precooked frozen meals by the catering industry for wholesale distribution to restaurants, canteens and airlines has stimulated interest in their possible use by hospitals.[5,6] Tentative experiments have been carried out with meals or foods already in commercial production, sometimes to meet special difficulties during the rebuilding of hospital kitchens. A successful pioneering experiment of this kind was conducted at the National Hospital for Nervous Diseases as early as 1946. Again, frozen or chilled meals ready for service have been found to be useful for staff on night duty.[7,8] More extensive trials in whole hospitals or sections of hospitals have also been conducted. Two such trials —at Greenwich and the Victoria Hospital, Blackpool[9]—have given results which at

one stage did not appear to be encouraging.[10] Finally, some hospital managements have reorganized catering to make full use of these new methods. In Stockholm, the Nacka Hospital has been preparing precooked food for distribution to several hospitals for some years. And, having compared work in Stockholm with experience at Blackpool, a team reporting to the Manchester Regional Hospital Board[11,12] has recommended the general use of deep-frozen precooked meals. Kaiser Foundation Hospitals[13,14] in California have been entirely dependent for ten years on pre-prepared food heated in microwave ovens. In Hamburg[15] hospitals catering for some thousands of patients are to have new kitchens for automatic cooking and deep freezing.

By these methods it is technically possible to produce meals of excellent quality and wide variety. With some methods the meal is only partially cooked and the final heating completes the cooking. Some systems use chilled food and not frozen food. Microwave ovens, which heat food by radiation at a wavelength of 12.3 cm. (2,450 megacycles/sec.), do not heat food satisfactorily unless it is first thawed. These factors could increase bacteriological risks. Centralized production should facilitate bacteriological control, but strict hygienic discipline is essential. [16-19]

The primary cost of frozen meals is greater than the cost of food conventionally cooked, but this may be offset by a more economical use of staff and reduction of waste, though use on a large scale is necessary.[20] The whole subject of hospital kitchens and distribution of food in hospitals is considered of such importance in Germany that it is being given detailed study by physiologists, nutritionists, architects, and engineers at the Institute for Hospital Building of the Technische Universitat, Berlin. In Great Britain the Royal Society of Health is to publish a report on a conference on hospital food held earlier this year at which these questions were discussed. There is no doubt that we shall hear more of these methods.—Reprinted from the *British Medical Journal*, 5410:645, 1964.

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Editorial Notes...

The American Trial Lawyers Association and the American Medical Association have been interested in the frequency of lawsuits based on alleged malpractice during emergency medical treatment at the scene of an accident. "Good Samaritan" laws are being passed to confer a degree of immunity for the doctor in such cases. After exhaustive research, neither association has been able to find one such suit. The conclusion is that, while there may be some justification for "Good Samaritan" laws, there is no legal justification on the basis of recorded lawsuits.

Much comment and some erroneous conclusions have developed following the news that corporate after-tax profits increased

45% **in the last three years, from $21.9 billion in 1961 to $31.7 billion during the second quarter of 1964.** However, the U. S. Chamber of Commerce points out that 1961 was a bad business year. When the present profits are compared to the Gross National Product, the percentage is 5.1. When this percentage is compared with two good years, 1955 and 1959, the answer is close to the same. In 1955, corporate after-tax profits amounted to 5.8% of the GNP and in 1959, the figure was 5.1%

Charitable donations by prescription drug companies almost doubled from 1961 to 1963. Last year the dollar volume of such donations, most of which involved replacement of retail stocks of drugs destroyed by natural disasters, amounted to more then $43 million. Donations increased by 72%, while sales increased only 17% ; taxes rose by 27% and the research budget went up by 19%.

The Dodd Bill, introduced by Senator Thomas J. Dodd of Connecticut, is designed to control the clandestine traffic in prescription drugs which allows amphetamine, barbiturates and other drugs to be abused on a wide scale. Smith Kline & French, producer of amphetamine drugs, is supporting the legislation, despite the fact that it will impose added record-keeping on all manufacturers. It is apparent that stricter controls are necessary to prevent the misuse of many of the most useful drugs.

Pilots of business airplanes are the principal subjects and beneficiaries of a new booklet published by the Industrial Medical Association. "Medical Aspects of Business Aviation" was produced with the cooperation of the Aerospace Medical Association. It discusses all the things which should be done by the industrial physician to determine the flying ability of pilots. It also discusses all the things that should be done to preserve the pilot's health and his ability to fly. About 30% of all non-military aircraft are company planes. The pilots are important in business. There are many medical considerations in addition to those attended to by a Federal Aviation Agency medical certificate. One of the important extra points not covered by government certification is the effect of medication on flying ability. An industrial physician has a large responsibility if his company owns a plane. Copies of the booklet may be obtained for 25 cents from the Industrial Medical Association, Chicago 60602.

The dangers of losing the advantages of new discoveries in drugs was dramatically presented in a *Readers Digest* article last October. James Daniel in "Threats to the Battle Against Disease" explains the despicable attempt to discourage research by cancelling patent rights. He also outlines the predicament of drug manufacturers who have their formulas and cultures stolen and sold to foreign makers, who in turn sell the drugs to the U. S. government at half or less of the domestic price because they do not need to recoup the expense of the research. The story has been reprinted. It should be distributed to every U. S. citizen.

The purification of sewage and industrial wastes and the consequent elimination of stream contamination is becoming a larger and larger problem with the increase in population density and recent industrial growth. The customary aerobic methods of bacterial purification are expensive because of the necessity for supplying oxygen. Scientists at Purdue University have discovered two types of bacteria which are anaerobic and do the job much faster. One type breaks down the waste material into digestible components and the other turns these into dissipating gases. Either one will function on wastes that are as much as 200 times as concentrated as ordinary sewage.

Nasal inoculations of weak Staphylococcus aureus can prevent subsequent acquisition of virulent staphylococci. *The American Journal of Diseases of Children* reports that a study performed on volunteers at the Atlanta Penitentiary shows that virulent staph infections of the nose will recur after being quieted by antibiotics unless nonvirulent staphylococci are introduced. This is like the tendency of the gastrointestinal

tract to be invaded by virulent organisms after the normal bacterial inhabitants are eliminated by the oral administration of broad spectrum antibiotics.

The number of applicants for admission to medical schools continues to increase on an absolute basis since the low of 14,381 in 61-62. Increase in the aggregate size of freshman classes, however, is holding down the ratio. The ratio of applicants to admissions is 2:1. In 1947-48 there were 2.9 applicants for each place. This ratio declined to a low of 1.71 in 61-62 and has now built up to only 2.0. In the school year of 63-64, 9,063 students were admitted.

Hospital fires were more numerous last year in the U. S. There were 1,500 fires, 300 more than in 1962. The monetary loss, however, was less. Nursing home fires increased by 100 to 700 and the loss doubled to $1 million. The total number of fires involving all types of property did not increase but the property loss reached a new high of $1,788,100,000. Arson in buildings increased by 29%, to a total of 30,900.

Hepatitis vaccine has been impossible to produce because, up to now, no experimental animal has been found susceptible to the disease. Attempts to infect the common laboratory animals, including most monkeys, have been failures or only partial successes. Now Tulane University has found a West African monkey, the Erythrocebus patas (patas for short) which may be susceptible. A new supply of patas monkeys is now being sought. The task of capturing 150 wild monkeys and transporting them to the United States without contaminating them with "human" viruses, including the hepatitus virus, is a real challenge. No one is promising the vaccine as yet, because even if the monkey business works out, the virus or viruses of hepatitis are difficult to work with and there are several strains to confuse the issue. And, just to make the investigation more difficult, if they can make the vaccine, it may not work.

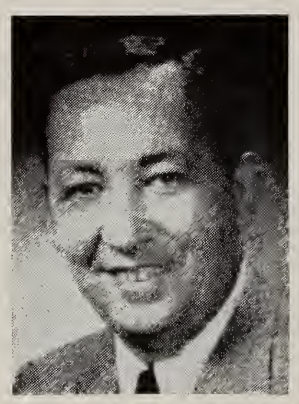
The AMA emergency medical identification symbol is now or soon will be valid overseas. All the 58 member countries of the World Medical Association will use the symbol in accordance with action taken by the WMA at its meeting in Helsinki this summer. International travelers will be afforded protection almost everywhere, due to the world-wide publicity concerning the symbol.

Every doctor has probably wondered at one time or another whether the amount of money devoted to medical research was not in danger of, or had not already exceeded, the supply of competent researchers. Spending for medical research in 1963 was 74% higher than in 1960 and 1,600% higher than in 1947. Whether too much money is spent for medical research or not, there is some comfort in the fact that we are in good company. All research is expanding rapidly, almost as rapidly as the medical portion. Medical research in 1950 expended six percent of the total bill for all research and development; in 1963, eight percent of the total. ◄



President's Page

Each year medicine makes many advances, both clinical and scientific, and each year organized medicine faces more complex problems— particularly in the socio-economic areas.



—Read *The Journal*—

We have a major problem in our own ranks — communications. It is the responsibility of *every* physician to become better informed on the issues of the day so that together, they will be able to heard and recognized by their fellow Americans.

—Read *The Journal*—

The Indiana State Medical Association is indeed fortunate to have an outstanding physician and friend as the editor of our journal, Dr. Frank B. Ramsey. Dr. Ramsey is presently president of the State Medical Journal Advertising Bureau. These are all time-consuming, responsible positions and a tribute to Dr. Ramsey by his fellow editors for his leadership, knowledge and ability. It is proper for all members of ISMA to be cognizant of our official publication and its staff.

—Read *The Journal*—

This year, your president will attempt to keep you informed of his problems (really your problems) and to some possible solutions or suggestions gathered from our commissions, committees, other state societies and the AMA.

—Read *The Journal*—

A few problems for you to think about are (1) Medicare (2) health facility planning; (3) medical education with its inherent responsibility for supplying adequate, well-trained physicians to the citizens of Indiana; (4) health insurance, its needs, limitations and our participation; (5) public relations and the image of the M.D.; (6) future conventions and (7) liaison with all other ancillary medical groups. These problems are large and wide in scope.

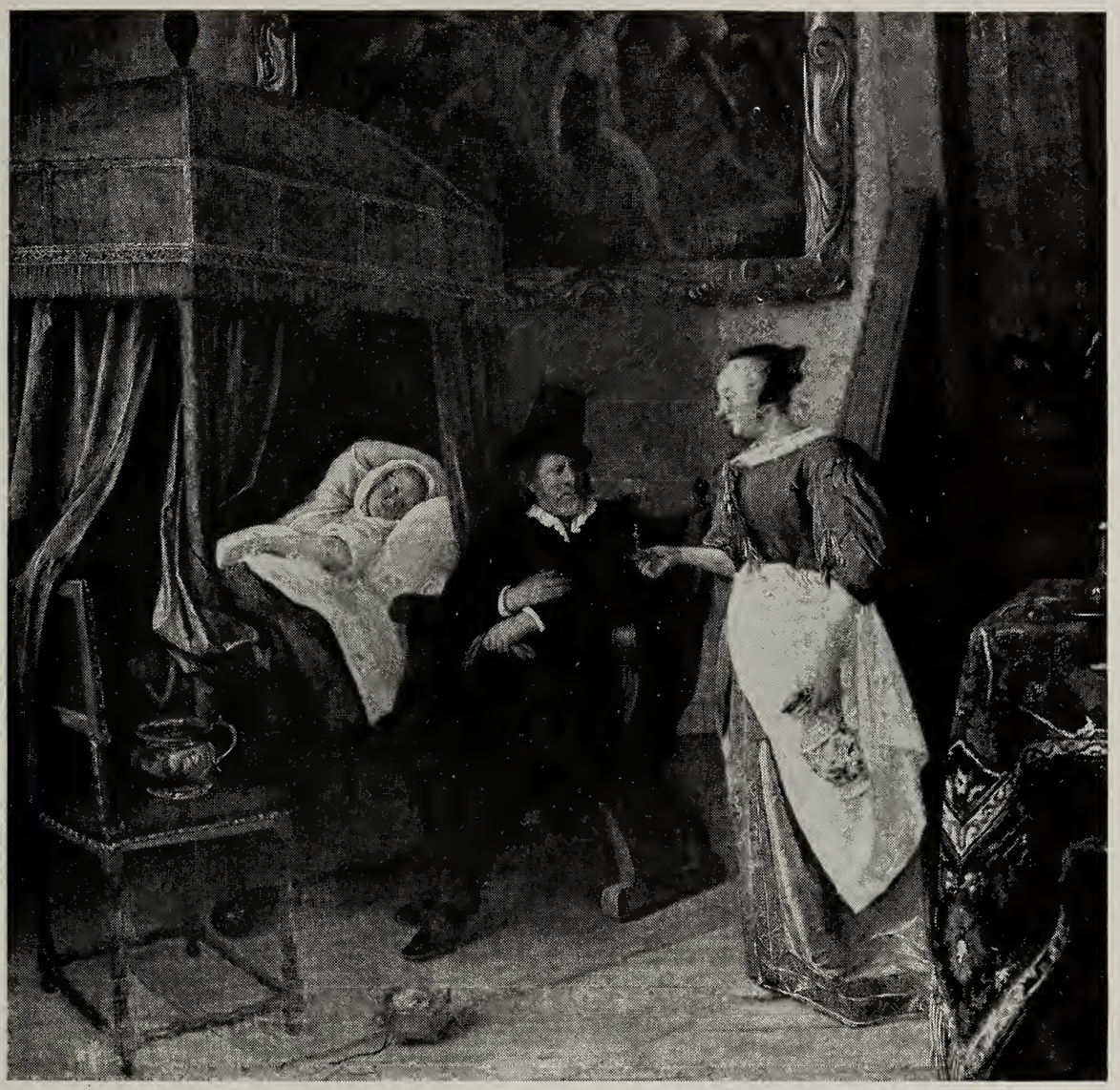
—Read *The Journal*—

The problems are many but the physicians of Indiana are capable and industriously working towards their solution.

—Read *The Journal*—

But enough of our problems. It is the time of year for all of us to prepare for a happy holiday season.





The Doctor's Visit, Jan Steen 1626-1679, Mauritshuis, The Hague

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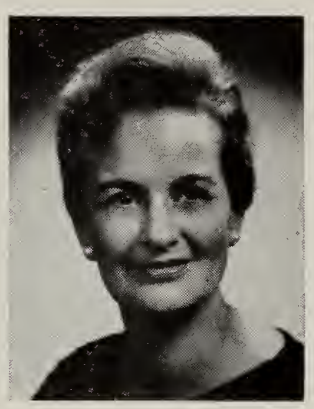
SEARLE

Research in the Service of Medicine

The Woman's Auxiliary

REPORTS TO ISMA

The state convention was enjoyed by all! There was a "hospitality center" for the women on Tuesday and Wednesday morning, more than 50 attended the general assembly and board meeting. One member described this meeting as "exciting"; each state chairman had but a short time to relay her message. The "Artists and Models" luncheon which followed was well attended and all enjoyed seeing the paintings by our own members and the style show. From the display of paintings, we could see that many of your wives are quite talented. We knew all were "model" wives but did not realize so many were artists!



As we approach the holiday season, we are aware that the true meaning of Christmas can be with us throughout the year. At any national, state or county meeting, we learn of opportunities for "giving" for "Better Health in a Better World."

Merry Christmas, doctor, and may the peace, hope and love which is Christmas be with you throughout the coming year!

Bea Shields

ILLNESS

ILLNESS

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Interpreted by
ROBERT HOLLOWELL, LL.B., legal counsel
Indianapolis

This memo relates to voluntary sterilization of a private patient at the patient's request and where no question of mental deficiency is involved. Where mental deficiency is involved, the procedure is covered by statutes in this state and the consideration thereof is not included in this memo.

In the middle 1950's, an article appeared in the *Bulletin of the American College of Surgeons* regarding sterilization operation. In that article, there was a statement to the effect that Indiana, among other named states, prohibited vasectomy and salpingectomy "unless performance of such operation is a medical necessity." Mr. Albert Stump, who was then an attorney for the Indiana State Medical Association, took exception to this classification of Indiana and so advised *The Bulletin* that in his opinion the publication was in error in its statement.

Since that time both Mr. Stump and myself have had occasion to review the law of Indiana upon this question. Neither of us were ever able to find a reported legal decision on the question by an Indiana Court of Appeal. The question was discussed in an article in the March, 1930 *American Bar Association Journal* (Justin Miller and Gordon Dean) which contains this statement:

> "In those states in which there is no penal provision prohibiting a sterilization operation by the modern methods; the general rule of tort law would seem to apply, and the consent of the party to submit to the operation should be a complete shield against civil liability on the part of the operating physician, provided the operation was performed without negligence."

In 1934 the question came up in *Christensen* v. *Thornby* (Minn.) 255 N.W. 260; 93 A.L.R. 570 and the court said:

> "We are not here confronted with the question of public policy as applied to sterilization where no medical necessity is involved. Aside from the statutes in the few states that have prohibited it, we find no judicial or legislative announcement of public policy against the practice of sterilization. Certainly, even in those states with the statutory prohibition, the exception of medical necessity would justify a physician in performing the operation here alleged. Plaintiff was married and presumably would remain married to his present wife, who had been competently advised of the danger of further pregnancy. The operation of sterilization upon a man is a simple one, accompanied by very slight hazard, where as that upon a woman is more serious and requires a greater degree of skill on the part of the physician. It entails hospitalization. It is frequently performed upon women who habitually miscarry or abort. So far as progeny is concerned, the results to this married couple would be the same were effective sterilization performed upon either. Therefore, in our opinion, it was entirely justifiable for them to take the simpler and less dangerous alternative and have the husband sterilized. Such an operation does not impair, but frequently improves, the health and vigor of the patient. Except for his

> inability to have children, he is in every respect as capable physically and mentally as before. It does not render the patient impotent or unable 'to fight for the king,' as was the case in mayhem or maiming. Liability of Physician for Sterilization Operations, *Am. Bar Ass'n. Jour.* vol. 16 (1930) p. 158. See Smith v. Wayne Probate Judge, 231 Mich. 409, 417, 204 N.W. 140, 142, 143. We therefore hold that under the circumstances of this case the contract to perform sterilization was not void as against public policy nor was the performance of the operation illegal on that account."

We have been unable to find any recent court decision directly on the question, although we have found several which have referred to a voluntary sterilization without criticizing it as illegal. In fact there is one case where a surgeon performed a sterilization operation upon a woman who had been advised not to have more children for health reasons. Apparently the operation was negligently performed and she later had a child by caesarean section and her health was impaired. The surgeon was held liable for negligently performing the operation in malpractice. I have found discussion on the moral aspects but no further authorities on the legal aspect.

I find no statute in Indiana prohibiting voluntary sterilization or making it a criminal offense.

Under the authorities above referred to, the laws and rules of practice would be the same as in any other operation.

There being no decided case in Indiana, I can only say that what little law there is in the texts and other states is to the effect of the above quotations.

In any such operation, unusual care should be exercised in obtaining written consent of the patient and in being sure the patient understands the entire situation. Also if the patient is married, consent should be obtained from the spouse.

A pamphlet entitled "A Reappraisal of Eugenic Sterilization Laws" was prepared by the Legal and Socio-Economic Division of the American Medical Association under date of May, 1960 and would be available upon writing the association. There was also an article of interest in the September 16, 1963, issue of *Newsweek.* ◄

Merry Christmas

The editor and the staff of The Journal wish you all

a Very Merry Christmas and

a Peaceful, Happy New Year



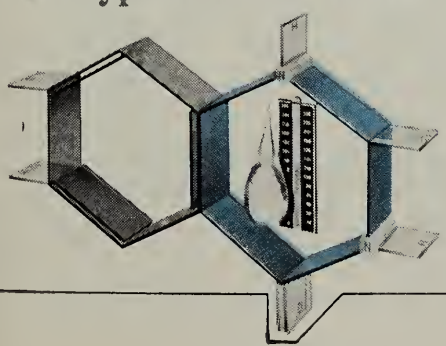
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CONTRAINDICATION: Anuria.

1. Steigmann, F., and Griffin, R.: Evaluation of Quinethazone, a New Diuretic. J. Amer. Geriat. Soc. 11:945 (Oct.) 1963.

2. Schwartz, M.: Office Evaluation of a New Diuretic in Patients with Hypertensive Diseases. Scientific Exhibit Presented at the Clinical Meeting of the American Medical Association, Los Angeles, California, Nov. 25-28, 1962.

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8370-4

Gleaned from the British Medical Journal

JACK W. HICKMAN, M.D.
Indianapolis

Mannitol Therapy for Oliguria

There has been a recent flurry of interest in Mannitol therapy in a wide variety of conditions resulting in decreased renal function. The present study documents the use of this compound in oliguria of recent onset.[1] Mannitol was used in ten patients; and in all these patients who had low urine concentration at the onset, prompt diuresis and a rise in urine osmolalita were obtained. The two patients in the series with well-established acute tubular necrosis showed no benefit from the Mannitol infusions. The author concludes that Mannitol's main use seems to be in the patients with incipient acute renal failure and feels that it can be of potentially great benefit in these cases.

Restenosis of Mitral Valve

One hundred patients are reported who underwent secondary surgical procedures for treatment of restenosis of the mitral valve.[2] This study confirms similar reports which have appeared in American literature in recent months that operations for restenosis have, in fact, often been greatly beneficial to the patients and can be undertaken with confidence. Results are far from perfect, but in the present series, 48 of the patients were regarded as excellent or good results. The operative mortality was five percent which is higher than that reported for initial procedures. The present authors performed the operation as a closed procedure, which differs from other authors who have suggested that open-heart surgery should be used in all second operations. Blind transventricular valvotomy is recommended as the operation of choice, and although others have seriously questioned this statement, the major point that reoperation can often be beneficial to a large number of these patients seems well founded.



Transfusion Viremia after Cardiac Surgery?

A rather unusual syndrome described as resembling infectious mononucleosis which has been observed to occur after open-heart surgery is documented by Smith.[3] The major factors of the syndrome are outlined as fever, splenomegaly and the presence of atypical lymphocytes in the peripheral blood. The author outlines nine such cases. Lymphadenopathy was present in seven of these patients, a higher instance than has been described before. Four of the patients also manifested a transient rubelliform rash. This manifestation had not been previously recorded. No definite etiologic factor is mentioned unless the syndrome might be a viral disease that is transmitted by blood transfusions which these people received during the open-heart procedures. Awareness of this condition is extremely important to all physicians involved in the procedures of open-heart surgery.

Hypothyroidism after Treatment for Hyperthyroidism

Two recent reports in the literature stressed that the development of hypothyroidism following I-131 therapy may be considerably higher than was once thought. The report by Green and Wilson[4] stresses the importance of this complication in patients undergoing either I-131 therapy or surgical therapy for hyperthyroidism at the University of Sheffield between 1949 and

1960. After partial surgical thyroidectomy, the incidence of hypothyroidism was found to be about six percent after ten years. Much more striking is the fact that 29% of those patients who received I-131 developed hyperthyroidism after the same time interval. While hypothyroidism can usually be controlled easily with the substitution of thyroid medication in such patients, such studies as the present one still indicate that we should take a close look at I-131 therapy and remember that in the hands of experienced thyroid surgeons, the incidence of this complication is considerably lower.

Chloride Levels in Hypercalcemia

Patients with hypercalcemia often present a difficult diagnostic problem. It is known that cortisone therapy will usually lower the serum calcium levels except in those patients with primary hyperparathyroidism. A report by Wills and McGowan shows that a laboratory procedure may be able to perform such a diagnostic function.[5] Sixty-one patients with hypercalcemia were studied. It was discovered that the 33 patients with primary hyperparathyroidism all had chloride levels of 102 mEq per liter or less, whereas of the 28 patients with hypercalcemia due to other causes, 27 had plasma chloride levels of over 102 mEq per liter. Apparently no mention of this finding has been made in previous literature and the present authors have no set explanation for it unless it is related to the derangement of the plasma bicarbonate levels that results from hypercalcemia. This finding appears to be extremely important and useful clinically and it is hoped that further confirmatory data will be presented in the future.

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Medicine At Law

DECISIONS AND OPINIONS

Highlights of recent court actions pertaining to health and medicine from *The Citation* prepared by the Law Division of AMA.

Ophthalmologist not Negligent in Failing to Perform Thoracotomy and Cardiac Massage After Cardiac Arrest—Upholding a trial court, an appellate court ruled that there was insufficient evidence to support a jury verdict against an ophthalmologist and an anesthesiologist for alleged malpractice during eye surgery. The appelate court upheld a judgment for defendants notwithstanding the verdict.

The patient, a six-year-old boy, was undergoing his second operation within about two months to correct some inward deviation of the eyes. During the administration of the anesthetic in preparation for surgery, the anesthesiologist suddenly announced that the boy's heart had stopped beating. He immediately let the anesthetic gases out of the bag, filled the bag with oxygen, and attempted to restore heart action by external massage, but without success. After 20 or 30 seconds, the anesthesiologist asked the ophthalmologist to open the boy's chest for heart massage, but the ophthalmologist replied that he was not qualified to perform such an operation. However, the ophthalmologist immediately summoned help, and a doctor who was just outside the door of the operating room and was partially prepared for surgery opened the boy's chest and began heart massage. Only about 20 to 30 seconds elapsed from the time the ophthalmologist declined to operate and the time the chest surgery began. However, about four minutes had elapsed between the time the heart was noticed to have stopped and the open heart massage was commenced. Although the child eventually responded to the open massage, he suffered extensive permanent damage as a result of the cardiac arrest. He became blind, mute, and a spastic quadriplegic and was confined to a state hospital.

The jury returned a verdict of $400,000 in favor of the child and more than $3,600 in favor of the child's mother. The plaintiffs had alleged that the cardiac arrest was caused by the negligence of the anesthesiologist and that the ophthalmologist was negligent in failing to perform a thoracotomy and cardiac massage upon the patient immediately after it was announced that he had suffered a cardiac arrest or in failing to have with him, as part of his surgical team, a surgeon qualified to do such surgery.

In holding that the evidence failed to support the verdict, the court relied on medical testimony. Insofar as the anesthesiologist was concerned, there was testimony that he had performed his duties in standard and acceptable fashion, and there was no testimony of any negligence on his part. There was testimony that the cardiac arrest was caused by stimulation of the vagus nerve on the heart, but the cause of such stimulation was unknown. Since cardiac arrest is a known, calculated risk of anesthesia, the doctrine of res ipsa loquitur did not apply, and the evidence would not support a finding that the cardiac arrest was probably the result of the anesthesiologist's negligence.

In holding that negligence on the part of the ophthalmologist had not been established, the court relied on expert testimony that standard medical practice did not require that an ophthalmologist be able to perform an emergency thoracotomy, although it was advisable in such circumstances for the ophthalmologist to do sur-

gery only when he knows that a general surgeon is in the immediate area. The ophthalmologist testified that he knew that a general surgeon would be in the immediate area, and a surgeon was, in fact, immediately available. Expert testimony also established the fact that sound medical practice did not require the presence in the operating room of a surgeon capable of performing a thoracotomy, if required, during an operation being performed by a specialist.

The hospital was also charged with negligence on the ground that the anesthesiologist was acting as its agent. Since there was no negligence shown on the part of the anesthesiologist, there was no liability on the part of the hospital.

Quintal v. *Laurel Grove Hospital,* 38 Cal. Rptr. 749 (Cal., May 27, 1964).

Workmen's Compensation Act Doesn't Bar Suit Against Doctor for Negligence in Treatment of Industrial Injury—A patient could bring a suit against a doctor for damages for injuries allegedly caused by the doctor's negligence in treating an injury the patient received at work, where the evidence did not show that the doctor was an "agent, servant or employee" of the patient's employer within the meaning of the Workmen's Compensation Act, the Texas Supreme Court ruled.

The personnel director took the patient to the doctor's office for treatment when he injured his finger at work. The patient later developed tetanus.

The Workmen's Compensation Act provides that an employee shall have no right of action against his employer or any agent, servant, or employee of the employer for damages for personal injuries. The doctor argued that since all of the parties conceded that he was engaged in work for the employer, it must be presumed that a master-servant relationship existed between him and the employer. When an employer or its compensation carrier arranges for and pays a particular doctor to treat employees injured in the course of employment, the doctor is generally expected to exercise and rely on his own professional knowledge and skill, without interference from the employer or the compensation carrier. There is no presumption then of a master-servant relationship, the court said.

The doctor was engaged in the general practice of medicine. About 15 or 20% of his practice was of an industrial nature. He was not on a retainer with the employer, but was paid for his services as they were rendered. The compensation carrier paid his charges for treating injured employees, and the employer those for making physical examinations. The fact that he was generally regarded as the "company doctor" and was paid by the compensation carrier did not conclusively establish that he was subject to the ultimate control of the employer or the compensation carrier in his treatment of industrial injuries. The evidence failed to show that the doctor was the agent, servant or employee of the patient's employer or its compensation carrier in rendering such services, the court ruled.

McKelvy v. Barber, 381 S.W. 2d 59 (Tex., July 8, 1964; rehearing denied, July 29, 1964).

Insurance Company Liable for $50,000 Penalty for Unreasonable Refusal to Pay Surgeon's Claim for Accident to Hand—Under a Louisiana statute, an insurance company was held liable for a $50,000 penalty and $20,000 in attorney's fees, in addition to a $50,000 policy claim for accidental injury to a surgeon's hand. Payment of the penalty and attorney's fees were directed because of the company's unreasonable refusal to pay the claim.

The surgeon lost three fingers of his left hand and injured his index finger as the result of accidental discharge of his gun on a hunting trip. It was admitted by all the expert witnesses that the doctor was incapacitated by this injury from performing surgery of any consequence.

The surgeon filed a claim under a clause in a group policy insuring him against "accidental loss of use of hand" incapacitating him from performing the duties of his profession. The company refused to pay the claim, contending that the surgeon was already incapacitated from performing surgery by previous heart trouble.

The group policy was one issued to the American College of Surgeons. Dispute as

to its interpretation centered around whether the words "directly and independently of all other causes," as used in the policy, referred to a requirement that the accidental injury be the sole cause of the loss of the use of the hand or whether the loss of the hand must be the sole cause of incapacitating the surgeon from practicing his profession. The court pointed out that the loss of the use of a hand would obviously incapacitate a surgeon and that the clause clearly and unambiguously referred to a requirement that the accident be the sole cause of the loss of the use of the hand. Therefore, evidence as to the surgeon's prior health was inadmissible.

In finding the company's refusal to pay the claim unreasonable, the court said that the policy was prepared by the company, presumably with a knowledge of the risks and of the legal meaning of its provisions. The company attempted to avoid payment of the Louisiana penalty by alleging that Illinois law governed. However, the court ruled that, since the policy was issued to a resident of Louisiana engaged in the practice of surgery there, it must have been intended to have effect in Louisiana, absent any provision to the contrary.

In the trial court, the surgeon was awarded $50,000 on the claim, but his request for penalties and attorney's fees were disallowed. On appeal by the company, the surgeon renewed his request for the $50,000 penalty and $20,000 attorney's fees and the appellate court granted the request.

Harmon v. Lumbermens Mutual Insurance Co., 164 So. 2d 397 (La., April 30, 1964). ◄



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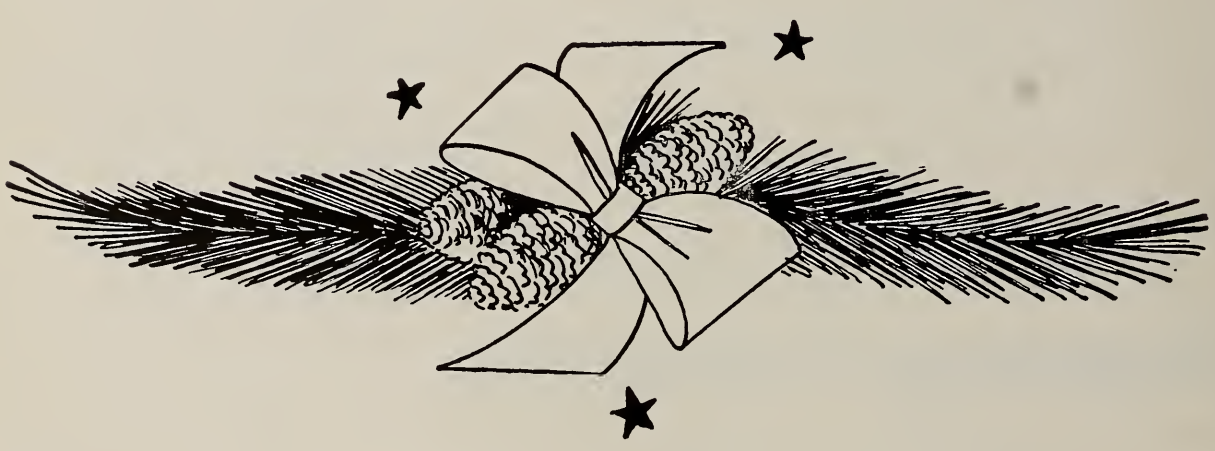
The comparison above comes from data in *Argus Chart 1964, Accident and Sickness,* the standard reference publication giving the operational data of the insurance industry. This comparison proves that Hoosiers can't buy protection against the cost of health care anywhere else at a price that is competitive with Blue Cross-Blue Shield.

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MONTHLY REPORT — October, 1964

Disease	Oct. 1964	Sept. 1964	Aug. 1964	Oct. 1963	Oct. 1962
Animal Bites	896	799	848	692	603
Chickenpox	205	26	28	107	128
Conjunctivitis	124	96	81	23	41
Diphtheria	0	0	0	1	1
Dysentery, Unspecified	237	47	51	81	37
Gonorrhea	262	361	351	308	Not Available
Impetigo	198	184	240	172	153
Infectious Hepatitis	43	35	24	43	66
Infectious Mononucleosis	47	32	15	16	6
Influenza	911	299	283	382	957
Measles (Rubeola-Rubella)	158	96	133	123	77
Meningitis, Meningococcal	4	5	3	2	1
Meningitis, Other	8	11	4	8	13
Mumps	173	96	158	139	55
Pertussis	50	40	29	21	36
Pneumonia	242	152	118	87	75
Poliomyelitis	2	4	1	0	5
Streptococcal Infection	497	395	345	291	278
Syphilis					
Primary & Secondary	9	6	4	7	Not Available
All Other Syphilis	118	94	109	168	Not Available
Tinea Capitis	47	4	6	9	14
Tuberculosis (Active)	120	89	110	111	121

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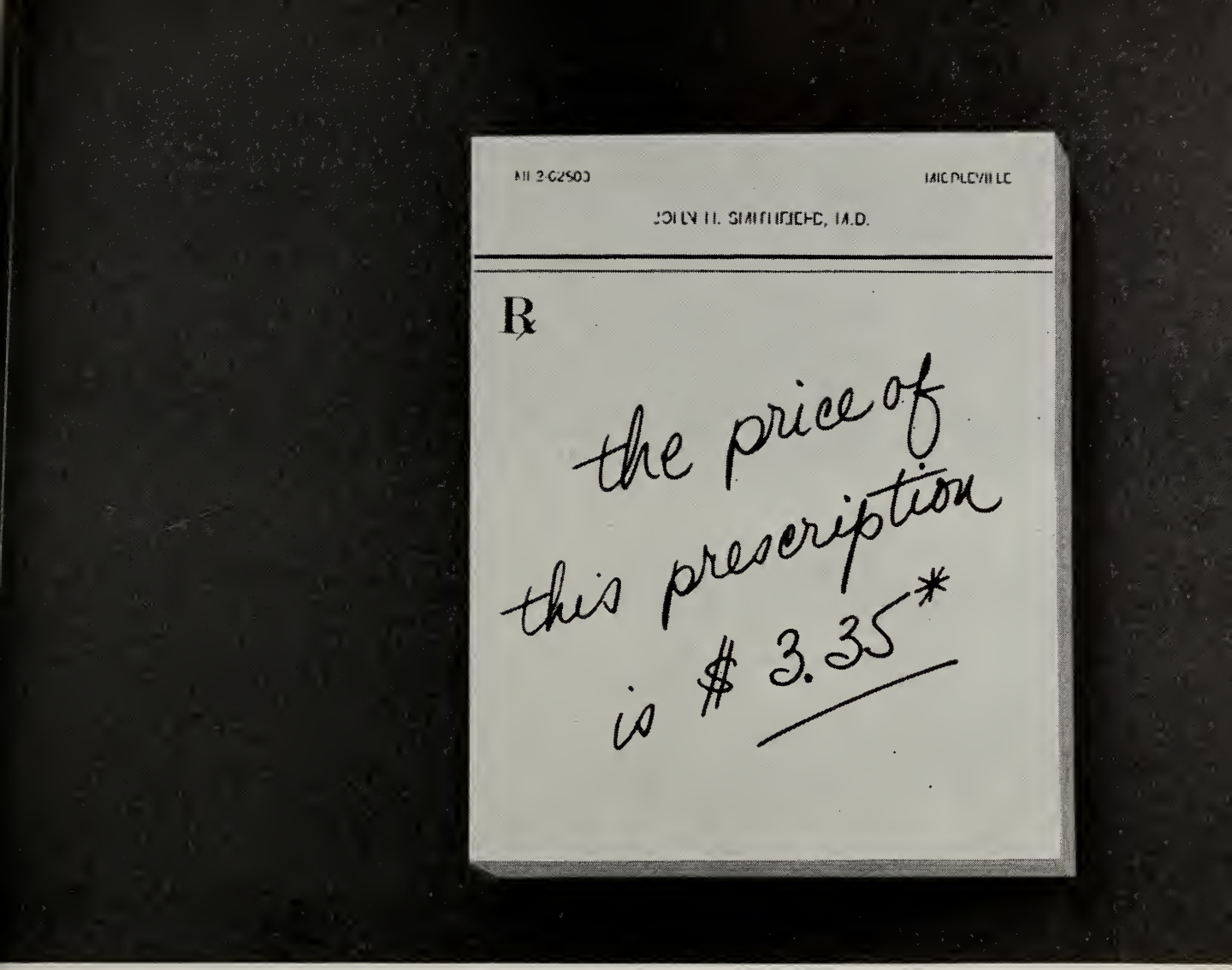
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ABSTRACTS

BOOK REVIEWS

CASE CAPSULES

The Droll, Diverting, Devilish, Definitely Different

Arnold Lieberman, M.D., Charles C Thomas, Springfield, Illinois, 1964; 356 pages, 145 illustrations. $9.50.

The 32 "tales" that make up this attractively produced book are no doubt familiar to regular readers of *The Journal* of The Indiana State Medical Association as all of them made their first appearance in print in this publication.

Dr. Lieberman, a consultant in internal medicine in New York City, has the enviable gift of distilling the pure essence of the episodes of tragedy, drama and humor that can occur in the life of any busy practitioner of medicine.

The illustrations, by Miki Wilson of San Anselmo, California, are as individual in style as the tales they illumine.

This book offers more than just diverting reading, however. It contains much that is new, unusual and informative. For example, *The Arthritic Arpeggio* with its knowledgeable discussion of scleroderma, collagen diseases and calciphylaxis; *Gender: Dubious*, a study of that, to many, still mysterious science of cytogenetics.

There is humor too, both whimsical, as in *The Upright Debauchee* and *Hypothyroid Constipation* and salty, as in *The Bloated Bartender* and *The Old Man who Died Young.*

The majority of the cases have valuable footnotes that emphasize the pathology under discussion and, in many instances, list books and monographs available to those who might wish to delve deeper into the subject.

The index, though not large, is detailed enough to be useful and, as an added convenience, publications are listed in italics.

This book would make an ideal gift for the practicising physician, the retired physician, the student or in fact, any person who is interested in medicine and, to imitate Dr. Lieberman's penchant for alliteration, in the foibles, frailties and fortitude of his fellow men.

E. ROGERS SMITH, M.D.
Indianapolis

Abstracts From Various Literature, Prepared by AMA

SYMPATHECTOMY IN THE TREATMENT OF FROSTBITE

H. B Shumacker, Jr., J. W. Kilman (Indiana University Medical Center, Indianapolis)
Arch. Surg. 89:575 (Sept.), 1964.

Sympathetic denervation has value in the management of the sequelae of frostbite, as confirmed by the author's experience with 52 sympathectomies in 30 patients. From a review of the literature and an analysis of the results of sympathectomy in 42 extremities of 25 patients, it is concluded that sympathectomy is also of real benefit in treating the acute manifestations of frostbite. It tends to bring about prompt disappearance of pain and edema, more rapid demarcation of any nonviable parts, more rapid healing of ulcerated areas and amputation stumps and very often actual conservation of tissue that would otherwise be lost.

PHENFORMIN (DBI) IN WEIGHT REDUCTION OF OBESE DIABETICS

D. P. Patel, J. M. Stowers (Diabetic Clinic, Royal Infirmary, Aberdeen, Scotland)
Lancet 2:282 (Aug. 8), 1964.

Phenformin was administered to 165 obese maturity-onset diabetics to induce weight loss as well as to control the blood sugar. Weight loss per month, expressed as a percentage of the "ideal" body weight, was greater early in the course of treatment, although it continued. The average divided daily dose of phenformin required merely to produce anorexia without other side-effects was about 75 mg, but there was considerable individual variation. Concomitant administration of sub-



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maximal doses of a sulfonylurea reduced the mean weight loss attributable to phenformin. The majority of patients were gaining weight before the phenformin treatment was started, whereas weight gain was very uncommon provided the dose of phenformin was increased slowly.

GASTRIC COOLING IN THE TREATMENT OF BLEEDING ESOPHAGEAL VARICES

J. G. Walker et al. (Medical Unit, Royal Free Hosp., London)

Lancet 2:328 (Aug. 15), 1964.

Gastric cooling arrested variceal hemorrhage in seven of eight patients with hepatic cirrhosis. In four of these, bleeding did not recur and one of them had a portacaval anastomosis. Three had a further hemorrhage two to 14 days later. In the eighth patient, profuse hemorrhage was diminished though not arrested, but emergency surgery was possible. The results achieved were similar to those obtained with vasopressin in a similar group of patients. The high mortality was a reflection of poor liver function rather than of the method of treatment. No complications of the treatment were seen, and it provides an alternative to the use of variceal tamponade or vasopressin.

CASE CLUSTERS IN THE OCCURRENCE OF LEUKEMIA AND CONGENITAL MALFORMATION

C. W. Heath Jr., M. Manning, L. Zelkowitz (Communicable Disease Center, Atlanta, Ga.)

Lancet 2:136 (July 18), 1964.

An unusual occurrence of births associated with congenital heart disease was observed in Niles, Illinois, at the same time as an increased prevalence of childhood leukemia. In Orange, Texas, a similar association was observed. These findings suggest the possibility of an epidemiologic association between some forms of leukemia and certain congenital malformations.

CHEAP, EFFECTIVE GASTRIC COOLING APPARATUS FOR CONTROL OF GASTROINTESTINAL HEMORRHAGE

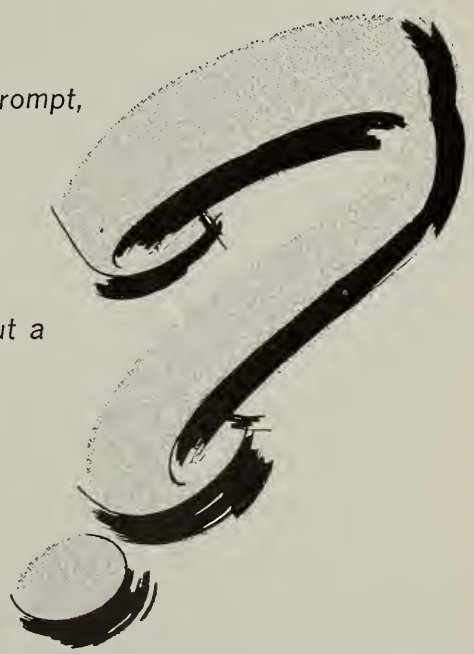
R. D. Henderson (10 Blyth Hill Rd., Toronto) and N. T. McPhedran

Canad. Med. Assoc. J. 90:1293 (June 6), 1964.

Gastric cooling (as opposed to freezing) is a useful adjunct in the management of upper gastrointestinal hemorrhage. Commercial machines for this purpose are expensive. This article describes a simple system in which cooled tap water is circulated through an extragastric reservoir using an applicator modified slightly from the original described by Wangensteen. The entire system can be made up in any hospital workshop at a cost of less than $10. Tested in the laboratory and clinically, it has been found to be easily set up, easily monitored, and safe; it has effectively controlled bleeding in seven of eight patients. ◄

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Indiana Flying Physicians Respond to "Mock Disaster" Call

Thirty-five Indiana Flying Physicians recently responded to a "mock disaster" in southern Indiana.

The Flying Physicians Association, working in conjunction with Civil Defense and the Indiana State Police, are on call at all times to respond to any emergency anywhere in the state.

"The call came on a Sunday morning, with bad weather threatening," said Dr. M. F. McGrath, state chairman of the association and currently one of its national directors. "There were strong winds, a cloud layer and thunderstorms threatening," he added, "and yet 35 of us answered the call."

The State Police notify the physician members of the organization. The alerts are totally unannounced in order to show how the doctors would respond to a real emergency or disaster. Each member of the organization has his own plane, which he donates along with his services.

"Each plane has four to five seats," Dr. McGrath said. "You are not wasting a seat that way with the pilot also being a physician," he added. The planes also carry a nurse and medical supplies.

These "mock disasters" are staged three or four times a year to keep the physicians on their toes.

Dr. Paul Sparks, Winchester, is national chairman of the disaster program and Dr. John Paris, New Albany, is state chairman.

Dr. Rhamy Appointed Professor

Dr. Robert K. Rhamy, Indianapolis, has been appointed professor and chief of the Division of Urology of Vanderbilt University School of Medicine. Dr. Rhamy has been associate professor of urology at Indiana University School of Medicine.

Dr. Parker R. Beamer to Leave for California

Dr. Parker R. Beamer, professor and chairman of the Indiana University School of Medicine's Department of Pathology is leaving for California at the end of December.

Dr. Beamer, a 1943 graduate of Washington University (St. Louis), has been at I.U. since 1953 and has served as chairman of the Pathology Department for the last two years.

He will be a member of the faculty of the University of Southern California Medical School and director of Laboratory Services at Los Angeles County Hospital.

Dr. Spitz Named Medical Director

Dr. Richard H. Spitz has been named medical director for Ames Company, Elkhart. Dr. Spitz was assistant professor of pediatrics and research associate in obstetrics and gynecology at Ohio State University.

Ophthalmology Papers Now Being Accepted for SMA Annual Meeting

The Section of Ophthalmology of the Southern Medical Association announces that papers are now being accepted for consideration for presentation at the next annual meeting which will be held in Houston, Texas, November 1-4, 1965.

Papers with a short abstract and the exact title should be sent at once and up to May 15, 1965 to the secretary, Dr. George S. Ellis, 812 Maison Blanche Building, New Orleans, Louisiana 70116.



JOHN H. GREIST, senior at the Indiana University School of Medicine, stops by the registration desk prior to the House of Delegates meeting at the October ISMA Convention. Dr. M. O. Scamahorn, Pittsboro, brought John with him to the session as a part of his preceptor training program. John spent six weeks working with Dr. Scamahorn in his office, in the hospital and in community activities. With them is Miss Elsie Reid of the ISMA office staff.

Norman M. Beatty Hospital Given Silver Award in Recognition

The Norman M. Beatty Memorial Hospital, Westville, received the silver award of the American Psychiatric Association recently.

The award was given to recognize the work that the staff of Beatty Memorial has been doing to further the growth of and the development of the mentally ill and retarded child during his hospital stay.

Larry Pickering Wins Award

Larry Pickering, executive director of the Fort Wayne Medical Society, recently won first place in a special membership drive of the Fort Wayne Chamber of Commerce.

Mr. Pickering won the award by acquired 22 new members and collecting delinquent accounts for the organization.

Crossroads Working with Retarded And Brain-Damaged Children

Retarded or brain-damaged children, either five or six-years-old, are being trained in a developmental program by the Crossroads Rehabilitation Center in Indianapolis.

Children who have not been able to gain admittance to regular or special education classes are eligible. The program is held daily for 2½ hours, five days a week. Admission is dependent upon referral by a private physician.

Ruth V. Kirk Retires; Honored By Medical Registration Board

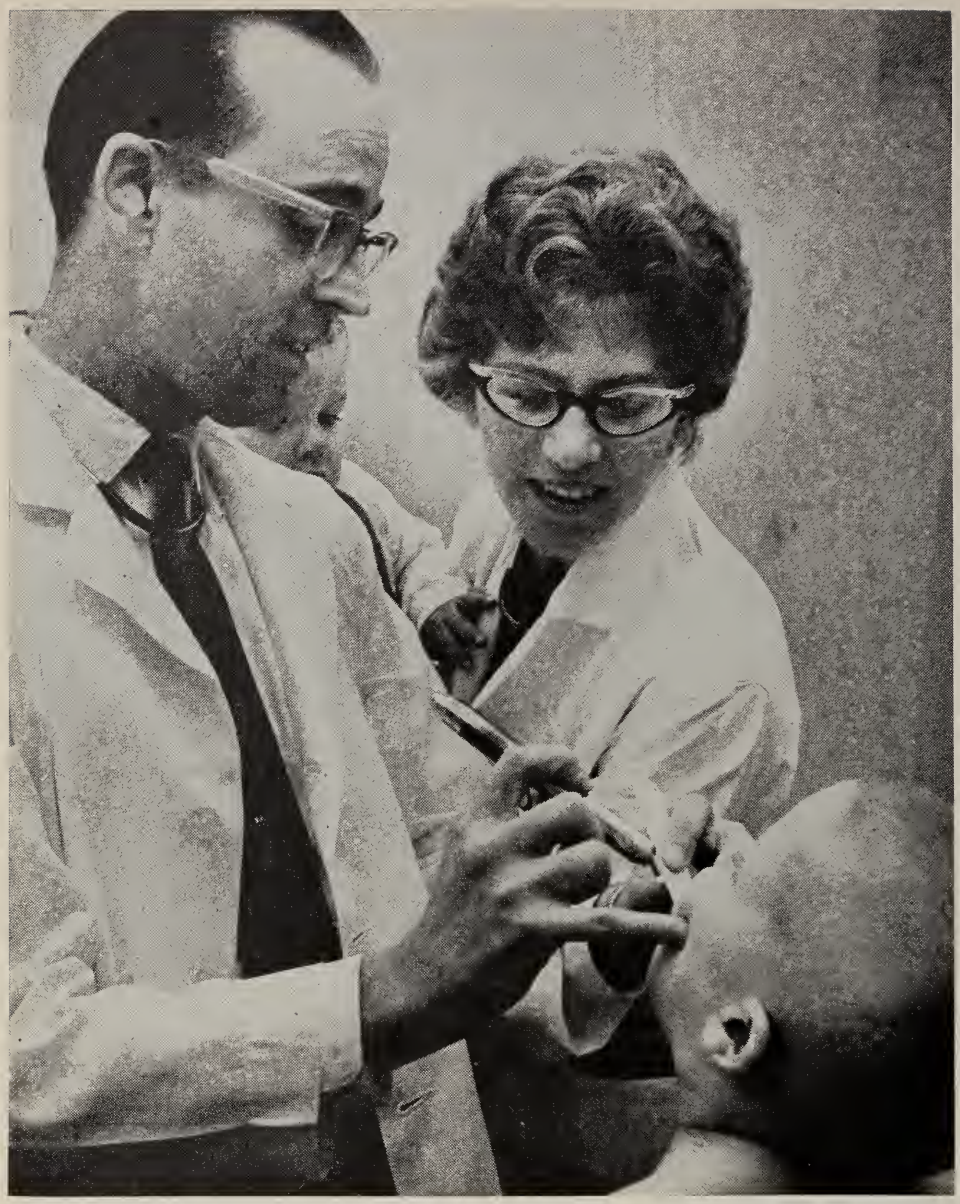
Miss Ruth V. Kirk retired recently after many years of efficient service as executive secretary of the State Board of Medical Registration and Examination. The board's resolution in commemoration of her faithful service reads as follows:

"RESOLVED, that, whereas the State Board of Medical Registration and Examination of Indiana has had many faithful and devoted employees, many of whom have served for long periods of time, and

WHEREAS, all who have rendered meritorious service to this board cannot be recognized, there is one who has served this board faithfully and unselfishly for thirty-one (31) years, and

WHEREAS, during these thirty-one (31) years, she has served some seventy to eighty (70-80) different board members, always maintaining their respect and confidence, and

WHEREAS, through her efforts and excellent public relations with other state medical boards, she has gained for herself and the State Board of Medical Registration and Examination of Indiana, not only local, state and national, but



ALICE JONELLE COONS, senior medical student at Indiana University, looks on as Winamac physician Dr. Edward L. Hollenberg, preceptor, examines a young patient. Miss Coons helped get the new ISMA and Indiana University Medical School program underway by being accepted as one of the first preceptees. The program was initiated in September under the auspices of the Commission on Medical Education and Licensure. Dr. Peter R. Petrich, Attica, chaired the commission.

international recognition and respect, and

WHEREAS, after these many years of outstanding service, she has seen fit to retire,

THEREFORE BE IT RESOLVED, that the State Board of Medical Registration and Examination of Indiana go on record to express our gratitude and sincere appreciation to Miss Ruth V. Kirk, for her many years of devoted and faithful service to the medical board and the citizens of the state of Indiana, and

BE IT FURTHER RESOLVED, that a copy of this resolution be recorded in the official minutes of this board, in executive session November 4, 1964, and,

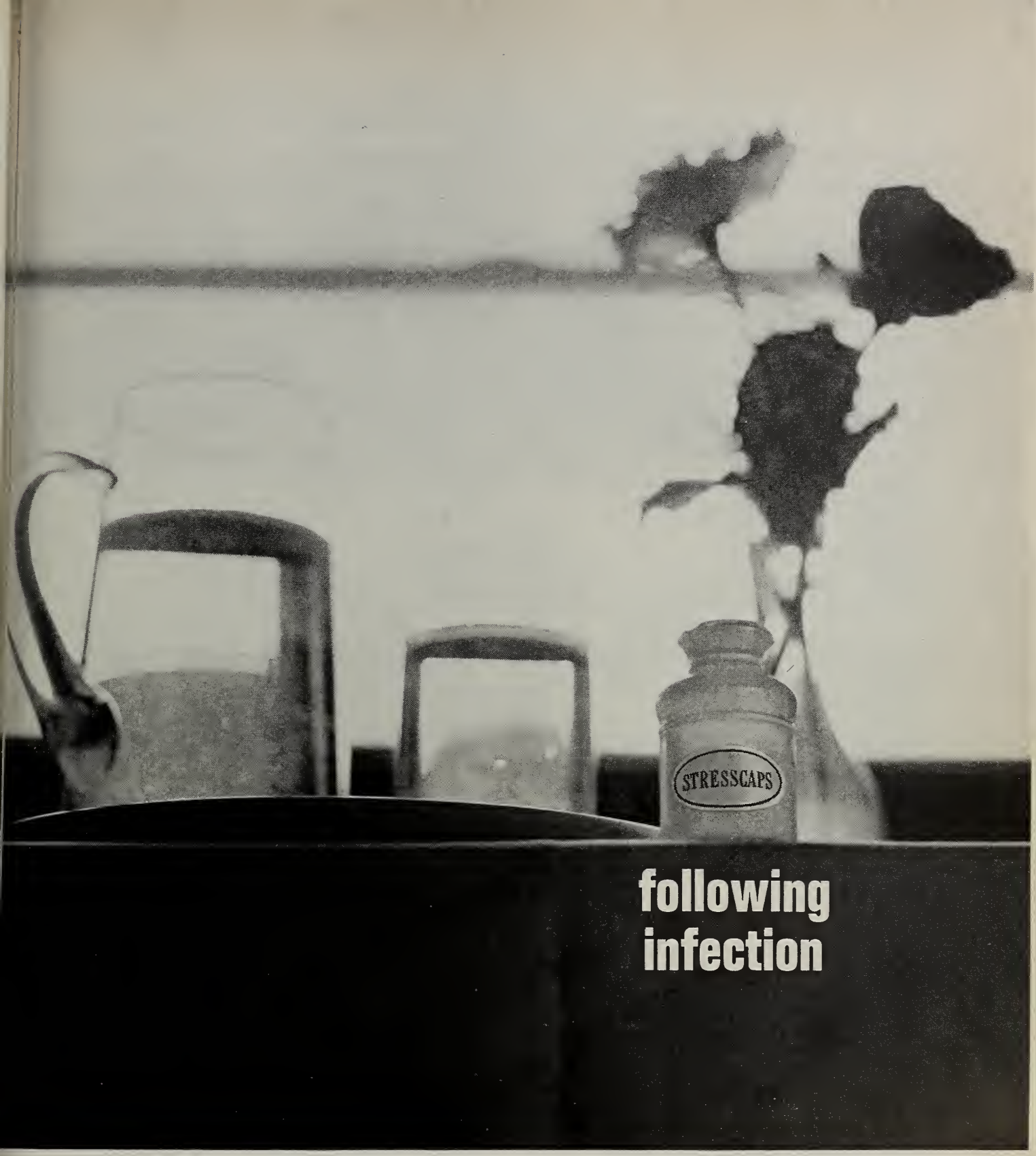
BE IT FURTHER RESOLVED, that a copy of this resolution be forwarded to Miss Ruth V. Kirk."

A. P. Bonaventura, M.D., *President*
P. T. Lamey, M.D., *Secretary*
H. Dearing Wolf, D.O., *Treasurer*
Merritt O. Alcorn, Jr., M.D., *Vice-President*
Richard H. Jowitt, M.D.
James C. Ploch, D.C.
Richard A. Snapp, M.D.
BOARD OF MEDICAL REGISTRATION AND EXAMINATION OF INDIANA

Dr. Max Bartley Honored by *Sports Illustrated* Magazine

Dr. Max Bartley, Indianapolis, is one of six physicians included on the 25-man squad of the *Sports Illustrated* Silver Anniversary All-America winners.

The 25 collegiate footballers, all of the class of 1940, were chosen not only for their football playing, but mainly for their outstanding contributions in life during the 25 years since graduation. Dr. Bartley was nominated by DePauw University where he played fullback on the varsity team. ◄



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FUTURE MEETINGS, SEMINARS, COURSES

New Orleans Graduate Medical Assembly to Meet Next March

The New Orleans Graduate Medical Assembly will meet on March 8, 9, 10 and 11, 1965, at the Roosevelt Hotel in New Orleans. This will be the 28th annual meeting.

The scientific program will present guest speakers who are outstanding teachers with long experience in postgraduate instruction. The registration fee of $25.00 will cover all the activities of the meeting. Full particulars may be obtained by writing the Graduate Medical Assembly at 1430 Tulane Ave., New Orleans 70112.

American Ob-Gyn Board Lists Tests and Application Data

Candidates participating in the Part I (written) examination of this board given on December 11, 1964 will be notified of the results of their examination on or before February 1, 1965.

All candidates who have completed 18 months each of approved progressive residency training in clinical obstetrics and clinical gynecology by June 30, 1965, will be eligible to apply for admission to the Part I (written) examination to be held on July 2, 1965. Application forms and current bulletins may be obtained by writing to the office of the secretary, Clyde L. Randall, M.D., American Board of Obstetrics and Gynecology, 100 Meadow Road, Buffalo, New York 14216.

Completed applications for the Part I examination in 1965 will be accepted in the office of the board only during January and February. Applications postmarked after February 28, 1965 will not be accepted.

California University School Of Public Health Sets Programs

The School of Public Health of the University of California at Berkeley announces four training programs—Basic Training in Maternal and Child Health; Training in Mental Retardation; Training in School Health and Career Development Program (Combined Training in MCH and Pediatrics).

Each program involves academic and field work for a period of from one to three years. Full particulars may be obtained by writing Helen M. Wallace, M.D., School of Public Health.

29th Annual Session of Medical Assembly Will Be in San Antonio

The 29th annual session of the International Medical Assembly of Southwest Texas will be held in San Antonio on January 28, 29 and 30, 1965, at the Granada Hotel.

Sixteen guest speakers will present a well rounded scientific program. All members of ISMA are invited to attend. More information may be obtained by writing the Assembly at 202 W. French Place, San Antonio 78212.

Cleveland Clinic Announces Course in Cancer Treatment

The Cleveland Clinic Educational Foundation announces a postgraduate continuation course in the "Treatment of Cancer" January 13 and 14, 1965 at Cleveland.

Registration fee for the surgical course is $30.00. Further information may be obtained from the Education Secretary, Cleveland Clinic Educational Foundation, 2020 E. 93rd St., Cleveland 44106.

Program Available for Diabetes In Review Clinical Conference

The American Diabetes Association today released the program for its twelfth postgraduate course, *Diabetes in Review*: Clinical Conference, 1965, which is to be held January 20, 21 and 22 at the Drake hotel in Chicago, in cooperation with the Diabetes Association of Greater Chicago. The faculty will be composed of 32 outstanding authorities.

The course is acceptable for accredited hours by the American Academy of General Practice. The fee is $40 for members of the American Diabetes Association; $75 for non-members. Additional data, the program and registration forms may be secured from the American Diabetes Association, 18 E. 48th St., New York, New York 10017.

Dermatology in General Practice Postgraduate Course Offered

The Mound Park Hospital Foundation, with the joint sponsorship of the Department of Medical Education of the Mound Park Hospital; the Florida Institute for Continuing University Studies, the American Academy of General Practice, and the cooperation of the Medical and Research Divisions of Bay Pines V. A. Center, and Pinellas County Medical Society, is pleased to announce a postgraduate course in "Dermatology in General Practice" on January 14 to 16, 1965.

All classes, meetings and clinical conferences though informal, will be consistent with the highest level of teaching practice. This program is acceptable for 18 accredited hours by the American Academy of General Practice. The teaching faculty will be composed of selected guest lecturers and qualified staff members. ◄

Letter

to the editor

I am writing to ask for your help in our solicitation of suggestions for inclusion in the forthcoming *Familiar Medical Quotations*.

We are particularly anxious to obtain the quotations of individuals who, unlike Shakespeare and Osler, have hidden their occasional gems so that only a few are aware of them.

Whatever help you can give us will be most appreciated.

Sincerely yours,
M. B. Strauss (signed)
Maurice B. Strauss, M. D.,
Editor

JISMA Editor's Note: *Familiar Medical Quotations* is planned as a collection of wit and wisdom from and about physicians of the ages. Nuggets of genius and brilliant good humor are being sought. If there is a favorite quote that you would like to see included, send it, with its source, to FAMILIAR MEDICAL QUOTATIONS, Little, Brown and Co., 34 Beacon St., Boston, 6.



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CASE CAPSULES

By

ARNOLD LIEBERMAN, M.D., Ph.D.
Consultant in Internal Medicine
New York, New York

With a Foreword by
FRANK B. RAMSEY, M.D.
Editor
Journal of the Indiana State Medical Association

Having read *The Case of the Upright Debauchee*, it is quite unlikely that any reader will put this book aside until he has delved into all thirty-two case capsules to the final *Case of the Barbed Barbiturate*.

Doctor Lieberman has produced in this collection a form so closely related to the actuality of science as to be educational . . . so fraught with the dramatic and humorous aspects of life as to be intensely entertaining. The tales are based on his own experience with just enough "fictional license" to preserve the anonymity of his patients.

This is no record of the bare bones of medical histories but rather of the things that make patients tick . . . the drama, emotion, irony and humor that are so intimately associated with the "art" of medicine.

1964 — 356 pages
$9.50 — 145 illustrations

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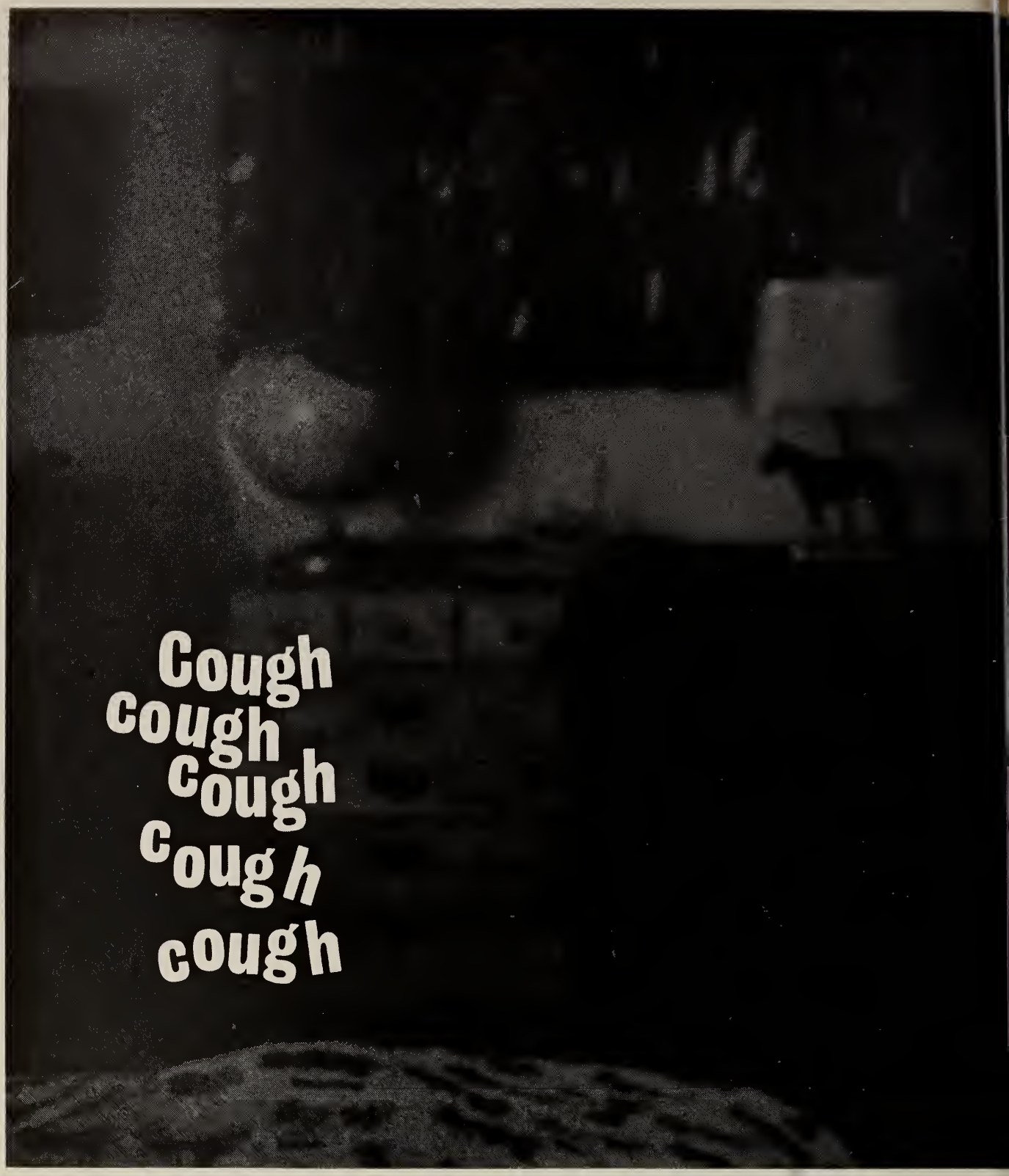
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County, District News

10th District

The 10th District Medical Society met Oct. 21 in Whiting to hear Arthur F. Endres, candidate for Congress and Bartel Zandstra, county auditor, speak. All of the 1964 officers were re-elected for another term.

Cass

Dr. Don E. Wood spoke on politics, the fall election and the upcoming annual meeting at the Oct. 5 meeting of the Cass County Medical Society. Forty-three members and guests attended the meeting.

Elkhart

Dr. Robert L. Tentler, associate clinical professor of neurology at the Stritch School of Medicine, spoke on "Recent Advances in Cerebral Vascular Disease" before the Oct. 1 meeting of the Elkhart County Medical Society.

Fayette-Franklin

A technical demonstration of the cardiac monitor and defibrillator highlighted the Oct. 13 meeting of the Fayette-Franklin County Medical Society.

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Grant

The Grant County Medical Society met Oct. 27 in Marion. Drs. E. S. Rifner and Robert M. Brown reported on the actions of the House of Delegates at the annual meeting.

Howard

Physicians and attorneys held a joint meeting Oct. 6 at the Howard County Medical Society meeting. The program, entitled "The County Coroner—An Anachronism?" was presented by four of the lawyers.

Montgomery

Mr. Howard Morris, of the Indiana University Medical Center, was the main speaker at the Oct. 15 meeting of the Montgomery County Medical Society. Seventeen members attended.

Owen-Monroe

A film on resuscitation was shown at the Oct. 29 meeting of the Owen-Monroe County Medical Society. There were 27 members present.

Shelby

The Shelby County Medical Society met Oct. 7 at the W. S. Major Hospital. Tine testing in cooperation with the Tuberculosis Association was the main topic discussed by the 16 members present.

White

Dr. A. J. Miller spoke before the Oct. 21 meeting of the White County Medical Society. There were eight members present.

Whitley

A case of Ollier's disease (dyschondroplasia) was the topic chosen by Dr. Warren L. Niccum when he spoke before the Oct. 13 meeting of the Whitley County Medical Society. There were 13 members present. ◄



Deaths

Thomas A. Hendricks

In 1924, The Indiana State Medical Association had the good fortune to obtain the services of Thomas A. Hendricks as executive secretary.



Tommy, as he was affectionately called, was a graduate of Princeton University, a newspaper reporter, had served in the State Legislature and was a genial, athletic individual. He was an excellent tennis player, a devotee of automobile racing and many other sports. He and his brother, Blythe, originated the broadcasting of basketball games.

There are just a few of us past-presidents still living who had the privilege and pleasure of having him guide and direct us through our two years as President-elect and President.

At his funeral, I was talking to Dr. Herman Baker of Evansville and we were reminiscing about some of the pleasant experiences we had with (or under) him. There were many pleasant memories of the trips we had made visiting district meetings. We were very sure that without his thoughtful help we would have been greatly handicapped.

I recall that in 1940 when the original Murray-Wagner-Dingell Bill was before Congress, Tommy, Dr. Verne Harvey and myself paid a visit to Paul V. McNutt, who was then Secretary of Health, Education and Welfare. We prevailed on Mr. McNutt to meet with the Board of Trustees of the AMA before the bill was to be acted upon. Suffice it to say, the bill was immediately killed.

In 1946, Tommy was given an important position in the AMA. We were glad for him but it was with great regret that we accepted his resignation. He served with the AMA until age forced him to retire. I should add that he was great help to our Indiana delegates during and after his tenure in office.

Only a few weeks ago, I called at the home of his daughter, Mrs. Hollowell, at Lake Maxinkuckee. She told me he was out playing tennis. I was aware of the fact that he was supposed to have had a coronary attack and suggested that tennis was rather a strenuous game. She said he loved to play and could still win and characteristically would have it that way. The next morning, I returned and he was out in the boat fishing with one of his grandchildren. He came in and we had an always to be remembered visit. He was intensely interested in killing or modifying Medicare.

Tommy never forgot Indiana medicine and whenever or wherever there was an important medical meeting, he was always present greeting and talking to old friends.

He loved people and always met them with a cheerful smile, an outstretched hand and a kindly word.

I sincerely doubt that he had a single enemy but it would take an IBM machine to enumerate his friends.

With his death, the medical profession and people everywhere lost a fine public servant, a gracious gentleman and a true friend.

KARL R. RUDDELL, M.D.
President, 1940

Paul J. Blessinger, M.D.

Dr. Paul J. Blessinger, 69, Jasper physician for more than 30 years, died Oct. 6 at the hospital at St. Pierre, Ind.

Dr. Blessinger went to Jasper in 1929 after being graduated from the St. Louis University Medical School. He taught school in Dubois county prior to studying medicine, and served in World War I. Dr. Blessinger was a member of the Dubois County Medical Society.

Irvin W. Ditton, M.D.

Dr. Irvin W. Ditton the oldest member of the Fort Wayne Medical Society, died Aug. 28 at the age of 92.

Dr. Ditton had practiced medicine in Fort Wayne since 1908, the year he was graduated from the I.U. School of Medicine. Before receiving his M.D. degree, he was a school teacher and surveyor for Allen county. Dr. Ditton held a 50-year honorary membership in the local, state and national medical societies.

Guy Martin, M.D.

Dr. Guy Martin, 65, physician and surgeon in Seymour since 1925, died Sept. 22 at General Hospital, Indianapolis.

Graduated from Indiana University's School of Medicine in 1924, Dr. Martin was born in Salem and had lived in Seymour for 39 years. He was a member of the Jackson-Jennings County Medical Society.

Harry P. Ross, M.D.

Dr. Harry P. Ross, former councilor, delegate and member of many ISMA committees, died July 18 at the age of 65.

Dr. Ross was graduated from the I.U. School of Medicine in 1923 and had practiced internal medicine in Richmond for many years. He had served on numerous committees of the ISMA, including Civic and Industrial Relations, Heart Disease and Student Loan; he was chairman of the Student Loan Committee in 1958.

A member of the Wayne-Union County Medical Society, Dr. Ross had served as its secretary for four terms; was an ISMA delegate from 1942 through 1953 and was Councilor from 1954 through 1961. He retired in 1962.

Charles A. Weller, M.D.

Dr. Charles A. Weller, an Indianapolis surgeon for 32 years, died Oct. 5 at Methodist Hospital. He was 78.

A native of Dale, Ind., Dr. Weller moved to Indianapolis in 1915 and practiced medicine here from 1918 to 1950, when he retired. A staff member in experimental surgery at the I.U. School of Medicine for many years, he also served on the staffs of Methodist, St. Vincent's and General Hospitals.

Dr. Weller received his medical degree in 1918. He was a member of the Marion County Medical Society and a Senior Member of ISMA. ◄

ANNUAL CLINICAL CONFERENCE

CHICAGO MEDICAL SOCIETY

March 1, 2, 3 and 4, 1965

THIS CONFERENCE IS DESIGNED TO BE OF INTEREST TO ALL PHYSICIANS. It is not sectionalized by medical specialties, but by types of disease entities. These will be presented in a manner designed to interest the generalist and specialist alike. All physicians, regardless of their principal areas of practice, should find much in this program which will be informative and useful.

For program or registration information address:

Clinical Conference Committee
Chicago Medical Society
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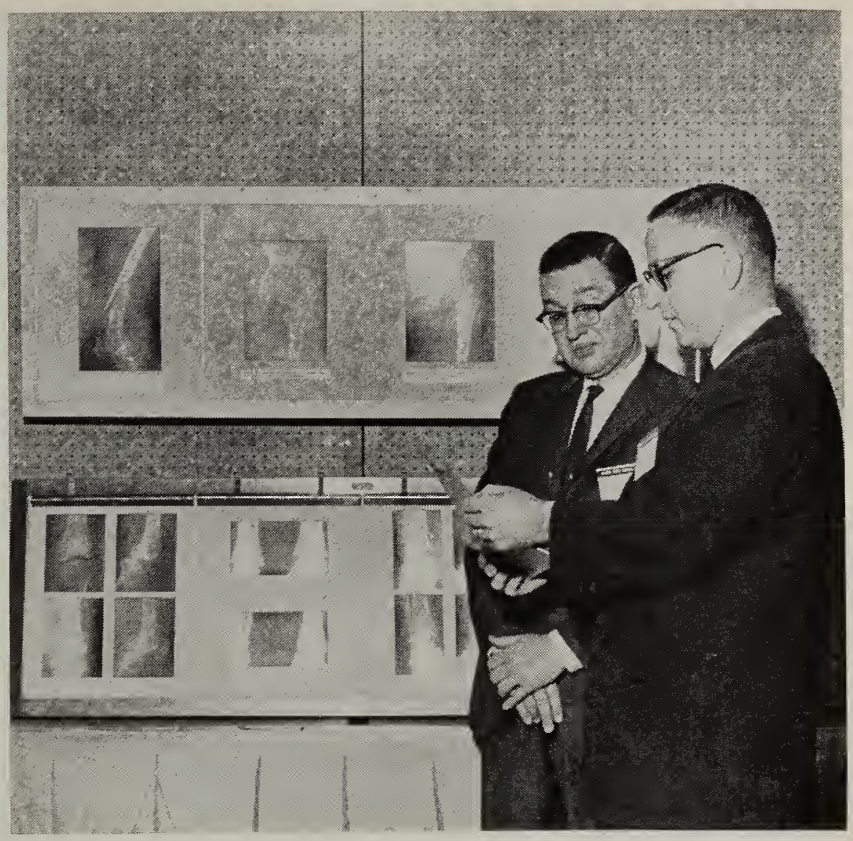
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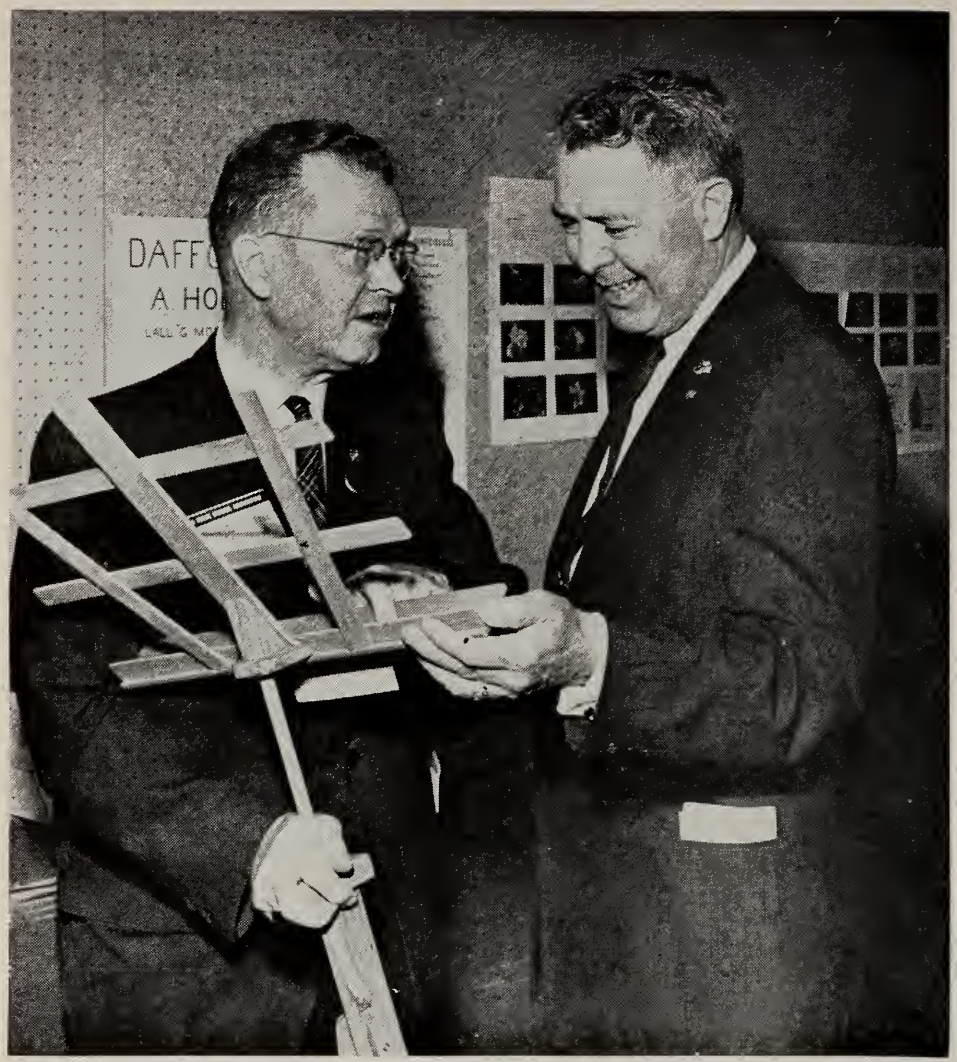
HOUSE OF DELEGATES members listen attentively to the proceedings of their first meeting Monday night.



SCIENTIFIC EXHIBITORS are always a point of interest at any convention. Dr. J. L. Haymond, Indianapolis pathologist, discusses one of the exhibits with Dr. R. G. Mehne, general practitioner from Brazil, Ind.



THE PAST PRESIDENT'S luncheon Tuesday brought together quite a few of the association's former presidents. Shown at the luncheon this year are (left to right) Drs. M. C. Topping, Terre Haute; Kenneth L. Olson, South Bend; Wm. Harry Howard, Hammond; Maurice Glock, Ft. Wayne; Herman M. Baker, Evansville; Earl Mericle, Indianapolis and Don E. Wood, Indianapolis.



THE ART AND HOBBY SHOW is another exhibit which evokes a lot of interest. Dr. Lall G. Montgomery, an annual exhibitor, discusses a music rack he made with Dr. Philip T. Holland, chairman of the show. The rack was fashioned out of various kinds of fruitwood from the Montgomery family orchard.



WOMEN PHYSICIANS also met this year for a dinner meeting as part of the convention.



MEMBERS OF THE EDITORIAL BOARD met Tuesday for their annual luncheon. Shown (left to right) are Dr. Lall G. Montgomery, associate editor; Drs. George M. Johnson and Irvin W. Wilkens, members of the board and Mrs. Mary Rogers and Mrs. Jackie Stahl, members of THE JOURNAL staff.



FIRESIDE CONFERENCES on Cardio-Respiratory diseases were a convention highlight again this year — the fourth year these conferences have been presented.



CONTINUOUS MOVIES were shown this year and drew capacity crowds.



THE FLYING PHYSICIAN'S ASSOCIATION met on Wednesday this year as part of the annual convention meetings. Attending the meeting were (left to right) Drs. Frank H. Coble, Edward D. Miller, J. F. McGrath, Dan L. Urschel, George Underwood, Norbert M. Welch and Gerald F. Ward.



"CHILD PSYCHIATRY" was the topic of the first Wednesday afternoon general meeting in the Egyptian Room.



"CEREBRAL VASCULAR INSUFFICIENCY" was the feature of the second Wednesday afternoon general meeting.



THE WOMAN'S AUXILIARY enjoyed their "Artists and Models" luncheon and style show Wednesday at the Columbia Club.



THE QUEUE formed early in the evening for the President's Reception and Gaslight Party at the Athenaeum.



ADDING A HALLOWEEN touch to the Gaslight entertainment was Mrs. Thomas Johnson dressed as a witch. That's Dr. Joseph Finneran disguised as a hairy gorilla.



THE PRESIDENT'S RECEPTION gave everyone a chance to meet the ISMA officers. Left to right, they are Dr. and Mrs. Jack Shields; Dr. and Mrs. K. O. Neumann, Dr. and Mrs. Joe Black and Dr. and Mrs. Don Wood.



THE GASLIGHT GIRLS mixed with the crowd as part of the evening's entertainment. Mr. and Mrs. Norman Nielsen and Mr. and Mrs. Milton DeBolt chat with one of the girls.



THE LARGEST ROOM at the Athenaeum looked like this after the early arrivals nabbed all available tables and chairs. Late arrivals were hard put to find a chair at all.



GETTING ACQUAINTED with the rinky-dink piano player were Dr. and Mrs. William M. Kendrick, part of the entertainment committee which put on the Gaslight party. Physicians who have formed a quartet were a part of the evening's program. The lower picture shows Drs. Hoyt Miller, Robert Nelson, David Ryan and Sherman Franz.





DR. JOE BLACK welcomed Senator Vance Hartke to the convention. Senator Hartke was one of the speakers on the Political-Social-Economic program Thursday morning at the general meeting.



50-YEAR CLUB MEMBERS toast each other with the traditional glass of champagne. New members this year were Drs. Will C. Moore, Muncie; Henry F. Nolting, Indianapolis and G. W. Bowdoin, Elkhart; Dr. Jerome E. Holman, Sr., chairman of the reception, toasts the new members.



THE ANNUAL LUNCHEON — always a convention highlight.



ARNOLD PHILLIPS, chief of the Indianapolis Fire Department, was presented a plaque at the President's Luncheon Thursday in recognition of the department's efforts at the Coliseum disaster.



JOSEPH K. SHEPARD, senior writer on The Indianapolis Star Sunday Magazine, was honored for his article on the emergency medical identification symbol.



DR. J. O. RITCHEY, Professor Emeritus of the Indiana University School of Medicine, was honored for his years of dedication and work in the fields of medical education.



SCIENTIFIC EXHIBIT winners pose with the plaques they were awarded at the President's luncheon. Dr. Patrick J. Dolan and Dr. Erich K. Lang were two of the winners.



NEW REGIME—Dr. Don Wood presents the presidential gavel to Dr. Joe Black.

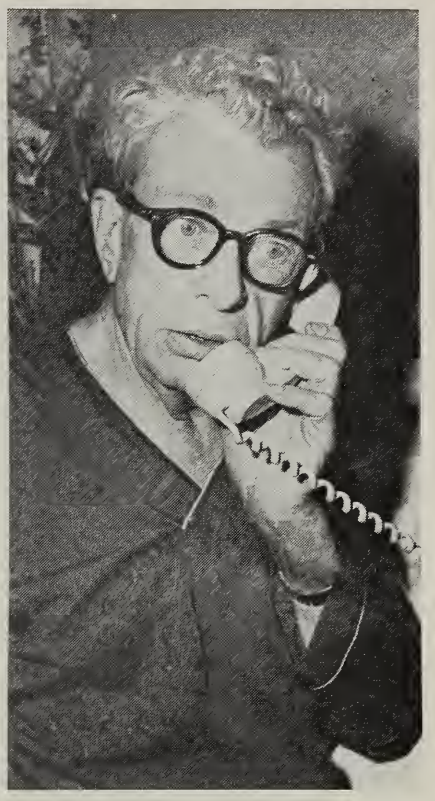


DR. JOE BLACK, president, 1964, presents the plaque to Dr. Don Wood, out-going president.



DR. JOE BLACK congratulates Dr. Kenneth O. Neumann on his becoming president-elect of ISMA.





HON. CHARLES HALLECK, Congressman from Indiana, introduced the main speaker at the President's Luncheon Thursday, Senator Everett M. Dirksen. The "Ev and Charlie Show" was slightly different here, however, as Sen. Dirksen was ill in a Chicago hospital. He addressed the convention via amplified telephone.



AN OVERALL PICTURE of the President's luncheon shows the large crowd which attended.

Convention Election Results:

Dr. K. O. Neumann Named President-Elect

Dr. Kenneth O. Neumann, well known Lafayette general practitioner, was elected president-elect of the Indiana State Medical Association at the closing session of the ISMA House of Delegates October 15.

Dr. Neumann was graduated from the I.U. School of Medicine in 1938 and after two years in hospital work, entered general practice in Lafayette. He served as a medical officer in the army from 1942 to 1946 and was discharged with the rank of major.

Dr. Neumann served for two years as Chairman of the Council and as a member of the Executive Committee. He has represented the Ninth District on the Council for the past eight years. In addition he has served as president of the Tippecanoe County Medical Society; the Indiana Health Officers Association; the medical staffs of the Lafayette Home Hospital and St. Elizabeth Hospital.

He has also served as chairman of the Section on Public Health and Preventive Medicine and has been a member of the Commission on Legislation, the Commission on Inter-Professional Relations and the Council Liaison Committee with Blue Shield and Blue Cross. He is now serving as a director of Blue Cross in Indiana and is a member of its executive committee; is a member of the Student Loan Committee and on the I-HOPE board.

Also taking office during the convention were Drs. Ottis N. Olvey, Indianapolis, elected treasurer; Lester H. Hoyt, Indianapolis, elected assistant treasurer and E. S. Rifner, Van Buren, elected chairman of the Council. Dr. Ralph V. Everly, Indianapolis, was elected chairman of the Executive Committee.

Re-elected delegates to the AMA for the two-year term ending December 31, 1966, were Drs. Harold C. Ochsner, Indianapolis, E. S. Jones, Hammond and Francis L. Land, Ft. Wayne. Drs. James H. Gosman, Indianapolis, Robert M. Brown, Marion and Frank H. Green, Rushville, were re-elected alternates for the same term.

Councilors who will represent their respective districts until Oct. 1967 are Drs. Donald M. Kerr, Bedford, Third District; William R. Tindall, Shelbyville, Sixth District; Peter R. Petrich, Attica, Ninth District; and Milton F. Popp, Ft. Wayne, Twelfth District. Dr. Robert M. Reid, Columbus, was elected to fill the unexpired term of Dr. Joe Black.

Alternate Councilors who will represent their respective districts until 1967 are Drs. Gilbert M. Wilhelmus, Evansville, First District; Jack E. Shields, Brownstown, Fourth District and Robert L. Rouen, Elkhart, Thirteenth District. Dr. Elmer L. Wallace, New Albany, was elected to fill the unexpired term of Dr. Donald M. Kerr, Bedford.

Results of the various section elections are as follows:

Section on Surgery: Clifford A. Wiethoff, Seymour, chairman; Ben King Harned, Jr., Evansville, vice-chairman; Donald W. Meier, Bluffton, secretary.

Section on Internal Medicine: E. Paul Tischer, Indianapolis, re-elected chairman; Charles M. Sinn, Evansville, vice-chairman; Robert L. Rudesill, Indianapolis, secretary.

Section on Ophthalmology and Otolaryngology: Milton W. Erdel, Frankfort, re-elected chairman; John M. Thompson, South Bend, re-elected vice-chairman; M. Richard Harding, Indianapolis, re-elected secretary.

Section on Anesthesiology: H. H. Frey, Jr., Lafayette, chairman; Richard Stein, Vincennes, vice-chairman; William M. Matthews, Indianapolis, secretary.

Section on General Practice: Leonard W. Neal, Hammond, chairman; Forrest J. Babb, Stockwell, vice-chairman; Ross L. Egger, Middletown, secretary.

Section on Obstetrics and Gynecology: Elfred H. Lampe, Ft. Wayne, chairman; Frank C. Donaldson, Anderson, vice-chairman; Joseph F. Thompson, Indianapolis, secretary.

Section on Public Health and Preventive Medicine: Robert M. Seibel, Nashville, re-

elected chairman; Kenneth O. Neumann, Lafayette, re-elected vice-chairman; John E. Arford, Warsaw, re-elected secretary.

Section on Radiology: Joseph G. S. Weber, Terre Haute, chairman; Louis C. Bixler, South Bend, vice-chairman; Richard A. Silver, Indianapolis, re-elected secretary.

Section on Nervous and Mental Diseases: Ronald Hull, Indianapolis, chairman; August Dian, Gary, vice-chairman; Gordon T. Brown, Indianapolis, re-elected secretary.

Officers of the newly created Section on Pathology had not been elected at the time this issue went to press. ◄

THE WINNERS—115th Annual Convention Indianapolis, Oct. 12-15

Art and Hobby Show

Class I — Oil Painting

First: Charles P. Schneider, M.D., Evansville — "Echo Lake"

Second: Dan W. Hibner, M.D., Indianapolis — "Winter in Indiana"

Third: Joseph W. Begley, Jr., M.D., Evansville — "Dog"

Class II — Black and White Photography

First: John Ling, M.D., Richmond — "The Way Up"

Second: Dr. Ling, Richmond — "Sun Flower"

Third: George N. Lewis, M.D., Gary — "Lovely Vision"

Class III — Color Photography

First: W. Burleigh Matthew, M.D., Indianapolis — "Indian Photographs" (group)

Second: William C. Seagle, M.D., Bloomington — "Fall and Winter Scenes" (group)

Third: Truman E. Caylor, M.D., Bluffton — flower photograph

Class IV — Drawing

First: Jack W. Hickman, M.D., Indianapolis — India ink drawing

Second: Dr. Hibner, Indianapolis — pastel

Class V — Crafts

First: Lall G. Montgomery, M.D., Muncie — (Fruitwood music stand)

Class VI — Collections and Hobbies

First: John D. Wilson, M.D., Evansville — (Indiana collection of relics and crafts)

Second: Dr. Montgomery, M.D., Muncie — (Daffodils, a hobby)

Third: R. H. Worley, M.D., Indianapolis — (Ancient coin collection)

Scientific Exhibit Award Winners—1964

First Place: Lymphography — Experience with 350 Cases

Exhibitor: Patrick A. Dolan, M.D., Indianapolis

Second Place: Diagnosis of Suprarenal Mass Lesions by Retroperitoneal Air Studies and Arteriography

Exhibitor: Erich K. Lang, M.D., Indianapolis

Third Place: Newer Concepts of Abdominal and Pelvic Arteriography

Exhibitors: T. R. Marshall, M.D., J. T. Ling, M.D., J. Amorocho, M.D., Louisville, Ky.

President's Address

DON E. WOOD, M.D.
Indianapolis

MY YEAR as your President is now completed. It represents a quarter of a century of activity in organized medicine's affairs. It has been rewarding. From these many experiences, I would like to make some recommendations for your approval and implementation in the Indiana State Medical Association. I would also like for the report I made to you in August to be included in my remarks.

I recommend that a provision be placed in the Constitution and Bylaws which would provide that from the effective date of the change, *all* members joining the Indiana State Medical Association for the first time be granted a provisional two-year membership. During this period they *shall* attend an orientation program as a qualification for a full fledged membership in the association. The program will be all inclusive of the association's activities, code of ethics and outstanding guest speakers.

Second, I recommend that it become the policy of the association that four times each year, preferably the same week-end the Council will meet, that all committees and commissions meet simultaneously. The commission and committee chairmen will then appear before the Council to give reports and make requests.

Third, I would recommend that the annual meeting be included as one of the four yearly meetings. The theme of the other three meetings would be in the area of public relations, the area of legislation and a medical society officers' conference. The orientation program would be provided at each of the last three meetings. This would provide the new members with six opportunities to avail themselves of this program.

In my opinion, this type of program would impart a feeling of an active association—a working association—not only to the participants but to our new members.

As a means of increasing the efficiency and effectiveness of our operations and at the same time reducing overhead costs, I further recommend that the association install its own printing department and addressing department which will handle all of our printing work with the exception of *The Journal*. I recommend that the association purchase addressograph equipment which will enable us to maintain our own mailing list. With the complexity of mailings required of our headquarters office, it would provide a means for mailing to doctors by specialty classification, by county medical society, by medical district society and by congressional districts. In fact, it would enable us to classify physicians 60 different ways and would greatly facilitate handling our mailings and providing information regarding physicians in a specific area.

At the present rate, our costs for having our addressing done on the outside and maintaining our lists during the next ten years, without additional inflation, will exceed $10,000 for this service alone. We can install this equipment at a total cost of $6,611.35 and this will, as I said before, enable us to handle all of our addressing, including that of *The Journal*. The equipment would last much longer than ten years, yet over the ten-year period, it would save us approximately $5,000 in service fees. The additional cost for purchasing all our plates and a cabinet for storing them, the necessary supplies to put us in business, will cost us $376.25. I would recommend the association approve the purchase of this type of equipment.

If you are interested in looking it over, I have arranged for its display in the Exhibit Hall so you may see what I am talking about, in Booth R-5.

I further recommend that the association purchase an offset printing press, as designed for office use yet will do everything that a large commercial press will do, such as multicolor printing, in order that all the materials such as our *Newsletter*, bulletins, promotional pieces, etc., can be done im-

mediately as the need arises, in our own plant. I would call to your attention that during the past year, the association has purchased from outside sources 182,268 pieces of printing, not including *The Journal* or reprints of *The Journal*. We have spent approximately $3,000 for this printing and the equipment people who have taken our statements for this printing and refigured them as to our cost allowing $7.00 per hour for our own labor, compute we could save approximately one-half of what we are currently paying. This piece of equipment installed and the training of our staff to operate it would cost $5,923.90. I highly recommend this proposal.

I do not believe there is an individual in this room who does not realize that medicine is involved in many areas which were foreign to our association activities just a few short years ago. We have all felt the impact which has been made upon our time and our activities by those who would bring an end to the private practice of medicine as we have known it these many years. We have seen the necessity for the association to maintain a more active and higher degree of public relations activity than has been carried on in the past. As we think of these things and as we think of the work which must be done in these areas to bring about a successful program of any type, we are talking in terms of manpower and money.

The day has long passed when we can depend upon the physician who is overloaded and overburdened in his effort to provide proper service to his patients, to do these things which we all realize should be done. Therefore, when we do not have the personal time to do the job, it means we must pay someone else to do it and provide the money to complete the program. As I said before, we have been able to procure money to purchase a series of Medical Self-Help classroom programs which we will put on the TV stations of Indiana yet this year. The stations have agreed to contribute their time but it is going to be necessary, inasmuch as the films were originally used in Illinois, that we change the lead and the conclusion of these presentations in order that the Indiana State Medical Association will be affiliated in the minds of the people as the organization presenting this program.

The cost of production, printing and adding fifteen 60-second introductions and fifteen 60-second closings by a member of our association will cost us a minimum of $250.00. We feel it will be necessary to provide 50,000 descriptive brochures on this program to acquaint the people with it and to gain their attention to this series. This cost is estimated to be $2,500.00. These brochures would be circulated to the industrial group and service, social and business organizations, schools, medical societies, medical society auxiliaries, press, radio and TV, Indiana State Board of Health personnel and other individuals requesting information. It will then be necessary for us to prepare 12 slides for use in TV promotion, which would cost us $160.00 for art work and production. Again, to make the knowledge widespread among the public of this opportunity to avail themselves of professional advice on medical self-help in case of a disaster, advertising should be inserted in papers in this area and this would cost us another $1,000.

Preparation of kits of promotional materials, which could be utilized by county medical societies in promoting the use of these films locally, would cost approximately $150.00. The 15,000 course completion certificates would be prepared to award to those who complete the classroom series at a cost of $250.00. In addition, the association would distribute 15,000 Family Guide Emergency Health Care booklets and 15,000 Medical Self-Help booklets. This one project alone, if we are to do it effectively, will cost us a total of approximately $7,000.00.

It has been my observation that we need to expand our entire area of public relations both with the public and within the membership. I believe the association should have a minimum of $1,000.00 available for the supplying of educational materials to students in our public schools who request it and to teachers who want aids in teaching public health education. I would believe we could spend judiciously a minimum of $6,000 per year on material for distribution on emergency call service; the medical

preceptor program: Student Loan program; and other services offered by the association to both the public and the membership.

I feel it is essential that additional staff be considered at this time. I would certainly recommend the employment of an additional individual who could serve part-time in field work as well as assist in the multitude of duties carried on by the headquarters staff. This, of course, would necessitate additional secretarial help and I would envision that judiciously we could spend an additional $16,000.00 per year for personnel. Our present staff has not enjoyed a cost of living increase for over two years. I think it is essential that we reward those who have been loyal to us over the years with a reasonable cost of living increase.

I would recommend that the Grievance Committee be re-named or re-constituted as a Judicial Council.

If we are to provide TV programs to the counties that would like such programs made available to them, this would cost approximately $5,000. I think there should be a contingency fund to be used as the occasion demands, of not less than $10,000.00. This would enable our Commission on Public Information and some of the other commissions to do much more constructive work in all their areas and particularly in the field of physician placement.

You can see from this the cost of informing the people and of promoting the cause of medicine is no small task and no inexpensive matter. I feel sure that every delegate and every member of this association wants to be proud of his organization and to feel that something is actually being accomplished.

Therefore, I hope you will see fit to give your future presidents and your future officers sufficient funds to bring these things into being and I would heartily recommend to the House that serious consideration be given these recommendations. ◄

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House of Delegates Proceedings

INDIANAPOLIS SESSION

October 12-15, 1964

The House of Delegates convened at 7:00 p.m., Monday, October 12, 1964, in the Ballroom of the Columbia Club, and again at 2:00 p.m., Thursday, October 15, 1964, in the Candidates Room of the Murat Temple, Indianapolis. Dr. Joe M. Black, the president-elect, called the first meeting to order and presided until Dr. Donald E. Wood, the president, delivered his presidential address. Dr. Wood presided at the final meeting of the House on October 15

Credentials Committee Reports

On motion of many, duly seconded, attendance slips signed by the delegates were accepted in lieu of a roll call at the first meeting. Dr. Robert M. Brown, teller, reported 102 delegates, six past presidents, nine councilors, two alternate councilors, the president, the president-elect, the treasurer, three delegates to the AMA, one alternate AMA delegate, the editor of *The Journal*, and 15 guests present at this meeting.

At the second meeting it was moved by many, motion duly seconded, put to vote, and carried, that attendance slips filled in by the delegates would constitute the roll call. Present for the second meeting, as recorded on signed attendance slips, were 90 delegates, five past presidents, 13 councilors, three alternate councilors, the president, the president-elect, the treasurer, three delegates to the AMA, one alternate AMA delegate, the editor of *The Journal* and fifteen guests.

According to Chapter IV, Section 3, of the Bylaws, 50 delegates constitute a quorum. The House of Delegates, therefore, was declared open and ready for the transaction of business.

The president read Chapter XXXII, Section 1, of the Bylaws, and Article XIV of the Constitution regarding amendments to the Bylaws and the Constitution.

In Memoriam

The House stood for a moment in memory of the following physicians who had served as members of the House of Delegates, or in an official capacity in the association and who had passed away since the 1963 convention:

IRVIN C. BARCLAY, Evansville. Delegate, Vanderburgh County, 1943; member of the Council, 1934-47; member, 1938, 1939, 1944, and chairman 1940-43, Liasion Committee with Indiana Crippled Children's Bureau; chairman, 1939, and member, 1940, Liaison Committee with Indiana State Department of Public Welfare; member, Advisory Committee to the Bureau of Maternal and Child-Health of the Indiana State Board of Health, 1945; chairman, 1948-49, and member, 1950-53-56-57, Committee on Constitution and Bylaws; member, Committee on Prepaid Medical and Hospital Insurance, 1949-50.

RALPH E. BARNETT, Peru. Secretary, 1942-43-46-47-48, and president 1956-57, Miami County Medical Society; delegate, Miami County, 1958 and 1960.

HERMA A. BECK, Lebanon. Secretary, Boone County Medical Society, 1909-10 and 1917; member, Committee on Inebriety, 1909-10.

HOWARD V. BLOSSER, Fort Wayne. Member, Committee on Convention Arrangements, 1939.

ROBERT F. BRAUNLIN, Marion. Secretary, Huntington County Medical Society, 1924.

OREN E. CARTER, Indianapolis. Member, Committee on State Fair, 1936.

LEE ALEXANDER DARE, Jeffersonville. Delegate, Clark County, 1959; president, Clark County Medical Society, 1960.

JOHN C. DAVIS, Logansport. Delegate, Cass County, 1948.

RALPH C. EADES, Valparaiso. Secretary, 1950, 1951, 1959, and president, 1954-55, Porter County Medical Society; delegate, Porter County, 1952-54 and 1958-62; member, Committee on Traffic Safety, 1950-53; member, Committee on Heart Disease, 1953; member, Committee on Rural Health, 1954; member, Committee on Scientific Exhibits, 1955; member, Essay Committee, 1956; member, 1958-61 and 1963, and chairman, 1962, Commission on Medical Education and Licensure; alternate councilor, 1959-61, and councilor, 1962.

JOHN C. ELLIOTT, Guilford. Member of the Council, 1940-44; secretary, 1936-47, and president, 1954, Dearborn-Ohio County Medical Society; member, Committee on Industrial Health, 1944; delegate, Dearborn-Ohio County, 1945, 1959.

CLYDE GRAY, Cloverdale. Delegate, Putnam County, 1937.

MERLE D. GWIN, Rensselaer. Secretary, Jasper-Newton County, 1912-15; member, Committee on Health and Public Instruction, 1914-15; delegate, Jasper-Newton County, 1937.

HAROLD D. HILL, Richmond (formerly Noblesville). Secretary, Hamilton County Medical Society, 1939-42; president, Wayne-Union County Medical Society, 1960.

FRANCIS J. KLEINMAN, Hebron. Delegate, Porter County, 1935; member, Committee on Cancer, 1953; president, Porter County Medical Society, 1959.

GEORGE A. MAY, Madison. Delegate, Jefferson-Switzerland County, 1934-35, 1940-41 and 1958; member, Committee on Prevention of Traffic Accidents, 1941; member, Committee on Rural Medical Care, 1945-47; member of the Council, 1948-50; chairman, Committee on Constitution and Bylaws, 1950; member, Committee on Physical-Hospital Relationship, 1950; member Cancer Committee, 1953; member, Committee on School Health and Physical Education, 1954; member, Committee on Convention Arrangements, 1955; member, Committee on Chronic Illness, 1957; member, Commission on Voluntary Health Agencies, 1958; member, Commission on Special Activities, 1960-63

PAUL MERRELL, Indianapolis. Secretary, Marion County, 1942-43, 1952-53; delegate, Marion County, 1954.

TREVALYN W. OMSTEAD, Huntington. Member,

Committee on Venereal and Communicable Diseases, 1957.

THOMAS R. OWENS, Muncie. Secretary, Delaware-Blackford County, 1928-33; member, Committee on Secretaries' Conference, 1928; delegate, Delaware-Blackford County, 1935-37; member, Committee on Tuberculosis, 1948-49, 1953, 1955, and chairman, 1956; member, Committee on State Fair, 1953.

HARRY PANDOLFO, Indianapolis. Member, Committee on Physician-Hospital Relationship, 1952; member, Committee on Convention Arrangements, 1954, 1956; member, Committee on State Fair, 1955-57; member, Committee on Public Relations, 1957; delegate, Marion County, 1956-63; president, Marion County Medical Society, 1958; chairman, Commission on Public Information, 1958-59; assistant treasurer, 1960.

FRANCIS PRENATT, Madison. Delegate, Jefferson-Switzerland County, 1959-63.

ORAN A. PROVINCE, Franklin. Delegate, Johnson County, 1939-45, 1947-52; member, 1940-41, 1943, 1945, 1946, and chairman, 1942, 1944, 1947, Committee on Scientific Work; member, Building Committee, 1946.

HARRY P. ROSS, Richmond. Secretary, Wayne-Union County Medical Society, 1927-28, 1945-46; member, Committee on Secretaries' Conference, 1928; member, Committee on Civic and Industrial Relations, 1939 - 41; delegate, Wayne-Union County, 1942-53; member, Committee on Control of Cancer, 1945; member, Committee on Medical Education and Hospitals, 1946-52; member, 1952-54, and chairman, 1955, Board of Appeals on Patient-Physician Relations; member of the Council, 1954-61; member, Committee on Heart Disease, 1954-56; member, 1956-57 and 1960, and chairman, 1958-59, Committee on Student Loan.

ERNEST RUPEL, Indianapolis. Member, Committee on Convention Arrangements, 1924; secretary, 1928, and chairman, 1929, Surgical Section; chairman, 1931-36, and member, 1946, Committee on Scientific Exhibit; member, Editorial Board, *The Journal,* 1933-38, 1943-45; member, Permanent Study Committee on Health Insurance and National Medical Situation, 1939-40; delegate, Marion County, 1944-45; member Committee on Venereal Disease, 1945-49.

OSCAR T. SCAMAHORN, Pittsboro. Member of the Council, 1924-26; member, 1927-33, 1937-40, 1946-47, and chairman, 1934-36, Committee on Public Policy and Legislation; chairman, Medical Section, 1928; delegate, Hendricks County, 1935, 1937-42, 1944-63; member, Committee on State Fair, 1942; member, Committee on Medical Economics, 1945; member, Committee on Maternal and Child Health, 1956-57; member, Committee on Constitution and Bylaws, 1957; Physician of the Year, 1956; member, Commission on Constitution and Bylaws, 1958.

LOUIS H. SEGAR, Indianapolis. Member, Committee on Convention Arrangements, 1918; member, Committee on Graduate Education, 1937-38; member, Advisory Committee to the Bureau of Maternal and Child Health of the Indiana State Board of Health, 1945.

EARL M. SHENK, Kokomo. Secretary, Howard County Medical Society, 1912-13.

RODNEY D. SMITH, Bloomington. Secretary, Monroe County Medical Society, 1910.

PAUL R. TINDALL, Shelbyville. (Formerly Greensburg). Secretary, Decatur County Medical Society, 1913-14; member, Committee on Constitution and Bylaws, 1952-53; delegate, Shelby County, 1950-63; member, Commission on Legislation, 1958-63.

JOHN D. VAN NUYS, Indianapolis. Member, Advisory Committee to Bureau of Maternal and Child Health of Indiana State Board of Health, 1943-44; chairman, Committee on Postwar Medical Service, 1945-46; member, 1946, and chairman, 1947, Medical Relief Committee; member, Committee on Public Relations, 1948-49; member, Committee on Instructional Courses, 1950-52; member, Committee on Chronic Illness, 1951-52; member, Committee on Preceptorships, 1953-54; member, Subcommittee on Preceptorships, 1955-57; ex officio member, 1956-57, and member, 1958-63, Committee on Student Loan.

CHARLES A. WELLER, Indianapolis. Member, Committee on Industrial Health, 1943-47.

1963 Minutes

On motion of Dr. Lowell Painter, seconded by many, minutes of the meetings held at Indianapolis on October 14, 15 and 17, 1963, were approved as printed in the December, 1963, *Journal.*

Introduction of Guests

MR. FRANK JOHNSON, JR., president, Indiana Chapter of Student AMA.

ROBERT C. LONG, M.D., Louisville, Kentucky, member of the Board of Trustees of the AMA.

EDWARD A. PISZCZEK, M.D., Chicago, president, Illinois State Medical Society.

HENRY A. CRAWFORD, M.D., Cleveland, president-elect, Ohio State Medical Association.

1964 Reference Committees

The chairman announced the appointment of reference committees for the 1964 session as follows:

Sections and Section Work:
James M. Kirtley, Crawfordsville (Montgomery), *Chairman*
Myron H. Nourse, Indianapolis (Marion)
John R. Frank, Valparaiso (Porter)
Harry G. Becker, Indianapolis (Marion)
Paul J. Wenzler, Bloomington (Owen-Monroe)

Rules and Order of Business:
Lindley L. Gammell, Columbus (Bartholomew-Brown), *Chairman*
T. Neal Petry, Delphi (Carroll)
Rahim S. Farid, Brazil (Clay)
Emory B. Lett, Loogootee (Daviess-Martin)
William R. Shaffer, Greensburg (Decatur)

Medical Education and Hospitals:
Glenn W. Irwin, Jr., Indianapolis (Marion), *Chairman*
Francis L. Land, Fort Wayne (Allen)
Jack E. Shields, Brownstown (Jackson-Jennings)
Norvel D. Sisson, South Bend (St. Joseph)
Thomas M. Brown, Muncie (Delaware-Blackford)

Legislation:
Frank H. Green, Rushville (Rush), *Chairman*
Robert A. Hedgecock, Frankfort (Clinton)
Richard B. Juergens, Fort Wayne (Allen)
Philip J. Rosenbloom, Gary (Lake)
Ramon B. Dubois, Lafayette (Tippecanoe)

Public Relations:
M. C. Topping, Terre Haute (Vigo), *Chairman*
J. B. Nicosia, East Chicago (Lake)
Robert E. Bryan, Kendallville (Noble)
John D. Wilson, Evansville (Vanderburgh)
S. E. Bechtold, South Bend (St. Joseph)

Hygiene and Public Health:
Dean B. Jackson, Hartford City (Delaware-Blackford), *Chairman*
Lowell W. Painter, Winchester (Randolph)
Frank W. Oliphant, Mount Vernon (Posey)
Russell R. Hippensteel, Culver (Marshall)
Evart M. Beck, Indianapolis (Marion)

Amendments to Constitution and Bylaws:
Maurice E. Glock, Fort Wayne (Allen), *Chairman*
Kenneth L. Olson, South Bend (St. Joseph)
Earl W. Mericle, Indianapolis (Marion)
Glen Ward Lee, Richmond (Wayne-Union)
Gordon S. Fessler, Rising Sun (Dearborn-Ohio)

Reports of Officers:
A. E. Stouder, Kempton (Tipton), *Chairman*
Ray H. Burnikel, Evansville (Vanderburgh)
Wilson L. Dalton, Shelbyville (Shelby)
John R. Ball, Fort Wayne (Allen)
John O. Butler, Indianapolis (Marion)

Credentials:
Dean K. Stinson, Rochester (Fulton), *Chairman*
Earl W. Bailey, Logansport (Cass)
Michael Shellhouse, Gary (Lake)
Julius B. Wohlfeld, Bedford (Lawrence)
J. Neill Garber, Indianapolis (Marion)

Insurance:
Clarence G. Kern, Lebanon (Boone), *Chairman*
Truman E. Caylor, Bluffton (Wells)
Lowell I. Thomas, Indianapolis (Marion)
Floyd A. Boyer, Indianapolis (Marion)
Joe E. Dukes, Dugger (Sullivan)

Miscellaneous Business:
Eugene F. Senseny, Fort Wayne (Allen), *Chairman*
Peter R. Petrich, Attica (Fountain-Warren)
G. O. Larson, LaPorte (LaPorte)
Ottis N. Olvey, Indianapolis (Marion)
A. T. Stone, Indianapolis (Marion)

Amendments to the Constitution

By roll call vote of 108 to 1, the House adopted the following amendments to the Constitution: (Words or sections added are italicized; words deleted are in parentheses.)

(1) ARTICLE II — PURPOSE OF THE ASSOCIATION

The purposes of this Association shall be to federate and bring into one compact organization the medical profession of the State of Indiana, and to unite with similar societies of other states to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education (and to secure the enactment and enforcement of just medical laws); to promote friendly intercourse among physicians; to protect its members against imposition; and to enlighten and direct public opinion in regard to the great problems of medical care, and public health, so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life.

(2) *Article IV, Sec. 4* — (All members who, previous to the adoption of this amendment to the constitution, were certified as honorary members on the basis of the above qualifications, shall hereafter be classified as senior members.)

(3) *Article IV, Sec. 6 — c. Senior members who desire the benefit of medical defense as provided by the Bylaws of this association shall pay the amount stipulated in Section 1, Chapter XXIX of the Bylaws for this coverage.*

The present sub-paragraph "c" to be renumbered as sub-paragraph "d."

(4) ARTICLE V — HOUSE OF DELEGATES

The House of Delegates shall be the legislative and business body of the Association and shall consist of (1) Delegates elected by the component county societies; (2) the Councilors; and (3) the ex-presidents of the Indiana State Medical Association. The following shall be *ex officio* members: the President, the President-elect, the Executive Secretary, the Treasurer *and Assistant Treasurer* of this Association, and the delegates to the American Medical Association, all without power to vote, except in case of a tie vote, when the President or person presiding shall cast the deciding vote.

(5) ARTICLE VI — COUNCIL

The Council shall consist of (1) the Councilors, and (2) *ex officio* the President, President-elect, and Treasurer with power to vote, *and assistant treasurer without power to vote except in case the treasurer be absent.*

(6) *The House of Delegates rejected the proposed amendment to Article VI of the Constitution, as stated in paragraph 6, on a roll call vote of 86 to 30.*

(7) *Article VIII, Sec. 2* — The House of Delegates shall select the place (two) *five* years in advance for holding the Annual Convention.

(8) *Article VIII, Sec. 3* — Special meetings of either the Association or the House of Delegates shall be called by the President on petition of 20 delegates or 50 members. *Upon receipt by the president of such a petition of 20 delegates, or 50 members, the president shall within 30 days thereafter issue a call for such special meeting at a time and place to be fixed by the president. The president, in specifying the time of such special meeting, shall fix the same as soon thereafter as reasonable and suitable arrangements can be made.*

(9) *Article IX, Section 1* — The officers of this Association shall be a President, a President-elect, an Executive Secretary, a Treasurer, *an Assistant Treasurer*, and thirteen Councilors, each of whom shall be a member, except the Executive Secretary, who need not necessarily be either a physician or a member.

(10) *Article IX, Sec. 3* — The officers of this Association with the exception of the Executive Secretary shall be elected by the House of Delegates as the first order of business (of the last day of the Annual Convention,) *at the final meeting of the House of Delegates*, and no person shall be elected to any such office who has not been an active member of the Association for the preceding two years.

(11) *Article IX, Sec. 8* — A vacancy in the office

of Treasurer *or Assistant Treasurer* shall be filled by an election by the Councilors at the next regular meeting of the Council following the occurrence of such vacancy.

(12) ARTICLE XI — INCOME AND EXPENSES

Funds may be appropriated by the House of Delegates to defray the expenses of the Association, for publications, and for such other purposes as will promote the welfare of the profession. All motions and resolutions appropriating funds must be referred to the *Executive Committee and* Council for approval before final action is taken thereon.

Reports of Reference Committees

REPORTS OF OFFICERS

The following matters were referred to the Reference Committee on Reports of Officers. All reports will be found on the pages indicated in the September, 1964, Vol. 57, No. 9, *Journal* of the Indiana State Medical Association, with the exception of the president's address, which will be found on pages 1426-28, of the December, 1964, *Journal.* The addresses of the president-elect, the president of the Woman's Auxiliary, the supplementary report of the treasurer and the report of the Future Planning Committee are printed herewith.

President's address. (Portion concerning financial matters referred to Reference Committee on Miscellaneous Business; balance of report referred to Reference Committee on Reports of Officers).
President-elect's address
Executive Secretary (pages 1010-1013)
Treasurer (pages 1013-1016) and supplemental report
Chairman of Council (pages 1016-1019)
Councilors' reports (pages 1020-1024)
Executive Committee (pages 1028-1030)
Address of President of Woman's Auxiliary
Journal Editor (page 1024)
Delegates to AMA (pages 1025-1027)
Address of President of Indiana Student AMA
Report of Future Planning Committee

President's Address

The address of the president, Dr. Donald E. Wood, is printed on pages 1426-28, of the December, 1964, *Journal* of the Indiana State Medical Association.

REFERENCE COMMITTEE ACTION

Dr. A. E. Stouder, Kempton, chairman, presented the following report:

The Reference Committee on Reports of Officers had referred to it certain portions of President Wood's address and would like to call special attention to two items:

1. The proposed orientation program. We urge that a committee be established to implement the development of this program, and that the committee include representatives of the auxiliary, so that the wives also could be apprised of society activities.

2. That the state association and the county societies take steps to change the name of their Grievance Committees to Judicial Council.

The remarks of the president indicate that he has given much time and thought to the problems of our organization and the committee heartily endorses those statements contained in his remarks. You will notice that in the President's address there are certain areas and items not taken up by the Committee on Reports of Officers.

Those items had to do with financial matters and were referred to another committee.

Mr. President, we move the adoption of his remarks as presented to this House in their entirety.

(Motion seconded by many, put to vote, and carried.)

President-Elect's Address

DR. JOE M. BLACK, president-elect, addressed the House as follows:

For the privilege of serving the Indiana State Medical Association as its President for the coming year I am indebted to you gentlemen of the House of Delegates, to my colleagues at home and to my family.

The office of President of this association offers one of the greatest opportunities to serve its members. It is a responsibility and an honor — perhaps one of the highest in the lifetime of an individual. Serving as your President for the coming year, I ask your help, your guidance, and above all, your friendship. Having served in various offices of the association for a number of years, I am very much aware that the success of our endeavors depends upon the teamwork of all.

This year we celebrate the 115th anniversary of our existence, and a review of the history of our association, the problems we have faced in the past, and the progress we have made, can only sober our thoughts and make us seriously consider the critical times in which we are currently living. It is a time when each of us must stand up and be counted. It is a time when we must cooperate with each other. It is a time when all of us must put our shoulders to the wheel if we are to survive in the practice of medicine. Never has there been a time when it is more important that we conduct ourselves as good doctors and at the same time as patriotic Americans. If *free medicine* and *free Americans* are to survive — and I am confident they will — we must each become militantly patriotic.

Doctor Wood has devoted his energy and his time to fostering many advancements of this association. He has worked hard and long, not only in the state of Indiana but throughout the nation. Our battle for freedom and for constitutional government has been carried to every state by Don. Indeed we have been fortunate to have a man of his quality of leadership as the head of our association this past year.

We have just completed another cycle in which

we and our friends have been successful in warding off socialized medicine. Many times this past century attempts have been made to place health care of the people and to regiment physicians under government control. We had a very narrow escape this year. We can take the remarks of those who advocate government control of medicine and the health care of our people seriously. There can be *no doubt* in any of our minds that this is the goal of many, not only in government circles, but in the minds of those who counsel and advise many of our leaders. We, as the medical profession, stand as the last bastion. We are the bulwark which stands between socialism and a democratic form of government. This is not an obligation we accepted when we graduated from medical school and took the Hippocratic oath — but today the realization that we are the militant force, that we provide the leadership, that we set the example for others to fight for a continuation of our freedom — this is as important as the obligations we accepted when we became physicians.

There are many times when we, as individuals, disagree with each other, many times we find fault with our association on all levels, and this is as it should be. However, we have a common cause to which all of us, without reservation, can subscribe. The issue is clear. We must set the picture now, and with firm admonition, or else in years to come, others will not provide physicians the control of the treatment of the sick of our state and our country as we now have it. The generations of doctors who will follow us will have their fate in this matter determined by our recognition of the issues facing us today and by our resolute action today and tomorrow.

Medicine has much to which it can point with pride. It has brought about the current degree of health to all peoples of the world. We are constantly making strides toward further improving the health and well-being of our citizens. Medicine, over the years, has been in the front ranks in proposing measures and in implementing programs which have brought these things into being. We have agreed among ourselves that we will supply needed and necessary medical care to those who are in need, regardless of creed, color or race. This is one of the tenets of being a physician, which is as important in medicine today as is the golden rule of life in living.

As Dr. Wood has outlined in his presidential address, your association is a large, active, progressive organization. I only wish it were possible for each member of this association to have a first-hand working knowledge of the activities carried on by the association on behalf of not only medicine, but on behalf of the people as well. We have had a continual expansion in membership, in our activities and in program. We have tried to continue these on the same budget but this is near impossible. Therefore, I hope that each of you will seriously consider the remarks of Dr. Wood and that you will agree that your future officers and the association *must continue* to go forward.

The last session of Congress, which just closed, saw approximately 20,000 bills introduced into the House and Senate. Eight hundred and fifty of these bills concerned medicine and the public health. In the 1963 General Assembly, 125 bills were introduced affecting public health and medicine. In January we will see the reconvening of our state legislature and there is no reason to believe that we will not see in the hopper the same percentage, if not a *higher* percentage of bills dealing with medicine and health, than we saw in '63.

You are all aware of the committees and commissions of our association and the work which they are doing. I will not therefore take time to review their activities, but I can assure you that they will be busy during the coming year, studying, planning and trying to prepare for us a future course. Rather I will devote my time to emphasizing that we, as physicians, have a much larger responsibility than most citizens because we have become so acutely aware of the many problems facing this nation. We have a singular responsibility to all other fellow Americans to alert them to the perils as we see them all around us.

We must spearhead the renaissance of freedom! We must rid ourselves and the thoughts of our friends of the fixed idea that liberty in our country is imperishable. You may ask what liberties have we lost. Let me remind you that you have lost the liberty *to keep, to use* and *to save* that which you have earned. You have *almost lost* the freedom of the ballot, because the votes of our millions of citizens are nullified by the voting machines made up of millions of bureaucrats and their families. The loss of other liberties is a matter they are asking our Congress to approve. *We dare not grow complacent.* Our nation was not founded by weaklings! Our heritage of freedom was bought by those who bled and died that we might enjoy the privileges of this great country. We would be poor men indeed if we failed now to assume the same obligations for those who follow us in *medicine* and *freedom.* Thank you.

REFERENCE COMMITTEE ACTION

Dr. A. E. Stouder, chairman, continued with the report of the Reference Committee on Reports of Officers, as follows:

The president-elect's message was reviewed and is considered one of stimulation. Dr. Black emphatically points out that we, in the medical profession, are facing a political philosophy that is antagonistic to the practice of medicine as we know it today.

To counteract and fight this socialistic trend, we as physicians should take time to educate ourselves politically, our friends and associates. To show the people of our communities that we are united in our actions is mandatory. To practice good medicine is not enough today if we are to remain free doctors and free citizens. We must become knowledgeable and expressive about all phases of our country's actions today and tomorrow.

Mr. Chairman, I move the adoption of this sec-

tion of the report.

(Motion seconded by many, put to vote, and carried.)

DR. IRVIN W. WILKENS, treasurer, presented the following supplemental report:

"As Dr. Wood said, we are in the black. Each succeeding year it has been a little more difficult to stay in the black. During the year the funds have been shuffled from one pocket to another. As usual, as the last quarter of the year approaches, we have greater difficulty in staying in the black. As you know, our source of income is dues, and with the increase in activities of the society, the increase in cost of *The Journal* and expenses in general being higher, the problem of financing the last quarter is greater this year than in any previous year.

"As of the moment, we have a total of $52,111.75 in cash in the General Fund. The expenses for the remainder of the year include $18,940.00 for AMERF and $18,940.00 for the Student Loan Fund ($5.00 per member for each of these funds). Funds have been reserved for these payments. In addition, an amount in the sum of $36,000.00 will be required for the operation of the headquarters office during the last quarter of the year. This $36,000.00, plus several other obligations, gives us an estimated deficit of $46,461.02 for the last quarter.

"Now, the only way that we can finance this last quarter is to take the dues as they come in to pay the expenses of the last quarter. Each succeeding year, this will be a greater problem, and it will increase. Now, this is my own idea about the thing. You will recall that several years ago the House voted that $5.00 from each member's dues shall be placed in the Student Loan Fund. At the present time we are well situated in this fund and it would be possible for the House to delete this money of 1964 of $18,940.00. That will give us an extra little break. Likewise, if the House would see fit to rescind the original action and make this on a yearly basis as the Student Loan Fund needs it, it would also help. That would give us about $37,000.00 for the General Fund.

"Finally, in projecting the next three to five years, I can see nothing excepting that there will have to be a dues increase."

REFERENCE COMMITTEE ACTION

Dr. A. E. Stouder, chairman, continued with the report of the Reference Committee on Reports of Officers:

Report of Treasurer

After a review of the treasurer's report and discussion with Doctor Wilkens, this reference committee concurs with the obvious fact that immediate stabilizing financial steps must be taken to correct the depletion of reserves and the balancing of the budgets of this association. We wish to thank Dr. Wilkens for his years of dedicated service as our treasurer.

Mr. Chairman, I move the adoption of this section of this report.

(Motion seconded by many, put to vote, and carried.)

The reports of the Executive Secretary, chairman of the Council, councilors, Executive Committee, the editor of *The Journal* and the delegates to the AMA were read and approved with sincere appreciation for their devotion and continuing service to this association.

The reference committee discussed the compelling need for improving the communication between the association and its component medical societies. It is suggested that this problem be included in the consideration of the Future Planning Committee as recommended elsewhere in this report.

Mr. Chairman, I move the adoption of this section of this report.

(Motion seconded by many, put to vote, and carried.)

Report of Future Planning Committee to House of Delegates

I. Background and authority:

At the 1962 annual session of the AMA, three resolutions were submitted by Florida, Massachusetts and New York calling for a study of medical health care needs and future planning by the AMA to insure leadership in this field by the medical profession. The reference committee realized that the intent of these resolutions was to develop long range, objective analysis. It was the opinion of the reference committee that there should be developed long range planning to anticipate future needs of the public and the profession, and that this should be explored and developed by the separate state associations, according to their needs, and that the AMA hold conferences as these programs develop to exchange information to mutual advantage. This was approved by the House of Delegates.

At the annual session of the AMA in 1963, the Council on Medical Service reported a survey of the state associations revealed that only six states had specific committees engaged in long range planning. The Council concluded that (1) there is a reluctance on the part of some state associations to charge a single committee with the broad field of long range planning and (2) a program of long range planning would require specific budgetary and personnel allocations at the state level. At this same session, Massachusetts introduced another resolution which proposed that a separate committee of the Council on Medical Service be established to carry out the 1962 directive of the House. The reference committee questioned the need for the establishment of a separate committee of the Council on Medical Service at that time. It suggested that the Council which has six committees, establish a committee composed of the six chairmen to coordinate planning and to look to the future. They suggested that all inquiries on long range planning should be directed to the Department of Medical Service of the AMA. They recommended that the Council on Medical Service should:

(1) be urged to take that action necessary which would insure coordinated planning for the future,
(2) establish a clearing house of information available to state associations that have initiated or are implementing long range programs,
(3) disseminate information on long range planning programs to state associations and
(4) encourage all state associations to look upon the Council on Medical Service as a place to seek information on long range planning.

At the 1963 Clinical Meeting, the Council on Medical Service announced that:

(1) Reorganization of staffing in the Division of Environmental Medicine and Medical Services to coordinate related activities within the association and to further the association's capacity to meet socio-economic problems
(2) Some of the long range problems are:
 a. The necessity of continuing study of the socio-economics of medical care;
 b. the need for a study of the relationship of medicine to government at all levels, with increased surveillance of federal-urban relationships;
 c. the development and utilization of medical manpower;
 d. the need for plans to meet the challenge of the anticipated population explosion by 1970;
 e. the number of beds and type of facilities needed for the long-term patient;
 f. the role of physicians and medical societies in areawide hospital planning.

The Council on Medical Service recommended that the Council itself should serve as the long range planning commission with the help and advice of its committee chairmen. This was approved by the reference committee and adopted by the House.

A Commission of Medical Practice has been formed this spring at the AMA under the jurisdiction of the Council on Medical Service. Its scope includes the following problems:

(1) organization and delivery of medical services
(2) the kinds of personnel needed to perform health care services
(3) the professional training necessary for such personnel
(4) the legal authority which allows them to practice
(5) population growth and movement with environmental, economic and sociologic changes
(6) relation to health facilities (hospital nursing home, rehabilitation centers, group practice clinics, mental health centers, etc.) and their future roles in personal and community health care
(7) relation to professional schools, teaching hospitals and research centers
(8) governmental health services
(9) health insurance and retirement programs.

The determination of what kind of physicians will be needed, where they will be needed, what they will do, how they will do it, in what social atmosphere they will work, with whom (other personnel) they will work are among the other critical questions which will require study and thought. Conceivably new patterns of medical care may be required which will provide the optimal development and growth for the delivery of comprehensive health services.

The problems of the Indiana State Medical Association over the years have been conscientiously dealt with by each president and his official family.

Because of the complexity and varied nature of organized medicine's responsibility to itself and to the people of this state, the basic organization structure of the association was altered when the House of Delegates approved establishing commissions with broader areas of study than committees formerly had.

The commission plan as observed by many, has worked effectively. However, in a recent address before presidents of the component societies the question was asked, "Are they (commissions) here merely to exchange ideas and philosophies on the needs of medicine or are they here to inaugurate dynamic programs for the association, plans which can be put into timely and effective use . . . ?"

The idea was further expressed that the ISMA could become for each physician a better and more important factor in his life and practice. Without sufficient funds to develop plans and execute programs, the ISMA will not assume the leadership role which is being assumed by other groups, including the hospital boards, voluntary agencies, United Fund groups, community service organizations and others (government — etc.)

A leader in the AMA has stated that it is necessary that we convince society it is to their best interest for us to remain free to render health care under a free enterprise system. We cannot take for granted the privilege of practicing medicine and we must recognize the cost to us in terms of time, cooperation, effort and financial resources. We must not only recognize our opportunities, but we must face our responsibilities. To achieve a forceful leadership it is necessary for us to remain united in a common effort, and avoid the fragmentation through which our aims and principles could be thwarted.

Our objective is to furnish the best possible medical care to the members of our communities and to the citizens in our state in the fullest measure, expeditiously, with the greatest possible economy, under an atmosphere of freedom of choice and individual responsibility in so far as possible.

At the 1963 Annual Convention of ISMA the House of Delegates recommended that the president appoint a committee to explore the need of a permanent future planning committee and make some recommendations as to the functions of such a permanent committee and sphere of operations. In accordance with this, President Wood appointed the present temporary committee of five members.

II. Present Situation:

We are fortunate in our present organizational set up. The formation of the commissions four years ago with geographic representation in each commission of all district societies, plus well informed at-large members, and the increased terms of appointment, with staggered expiration of terms of service has greatly increased the productive capability of the commissions and has allowed several of the commissions to effectively plan action for several years ahead. However, there is considerable lack of funds and also a lack of stimulation and lack of understanding of future goals of ISMA or AMA as a whole.

One of the goals set at the time of formation of the commissions has not as yet been achieved. It had been hoped that each commission member would chair a similar commission at the district level, with county chairmen as members of the district commission. It was hoped through this channel to improve communications from the county society level to the state level and vice-versa. Perhaps it is too early in our evolution to expect this, and perhaps with continued effort this concept will come into full being.

In view of the foregoing statements, your committee felt that adequate future planning could not be left entirely in the hands of the commissions. Consideration was given to the possibility of the future planning being accomplished by the Executive Committee, which probably is in the position of having more complete knowledge of the day-to-day operation of ISMA than any other group. After considerable discussion, it was agreed that the day-to-day operations and housekeeping chores completely occupied the executive committee and they could not be requested to perform a long-term planning function without asking them to sacrifice a much larger portion of their time.

Next was considered the Council. In many aspects it is engaged in future planning, usually no longer than a year or two in advance. In many states the Council acts as the planning committee and has separate "think" sessions for this purpose. As presently constituted, our Council could accomplish this function either by formation of a sub-committee of the Council with extra, separate meetings; by increasing the frequency of the meetings to a bi-monthly basis, or by increasing the time of the Council meeting to two days and having the Council meet as a committee of the whole, so that adequate time could be given to the needs of future planning.

III. Statement of Principles and Objectives:

Certain basic assumptions must be made. In considering the future of medicine and our role in the social structure, are we willing to assume full responsibility for the planning, the organization, the delivery and the quality of health care or are we willing to relegate this to others less qualified — individuals who are primarily interested in other social and economic needs?

With this statement of assumption, it is the feeling of your committee that a separate, permanent, long standing committee be appointed as the Future Planning Committee or Commission. It is felt that the membership should be at least nine, with a term of appointment of three years, with staggered terms so that three members terms would expire each year and three new members be appointed. The president, president-elect, chairman of the Council and chairman of the Executive Committee and editor of *The Journal* should probably be ex officio members. The membership should be varied, according to experience, age, size of local county medical society and geographical area. Past-presidents would no doubt be able to contribute much in the way of experience, but certainly no more than three in this category should be included. As this committee deals in future aspects, at least one-third to one-half should be in an age group who would be in practice in the future contemplated, (up to 10 or 20 years distant). These should be men capable of becoming future leaders. There should be reasonable balance between practitioners from urban areas, from those engaged in general practice and those who are engaged in specialties. "To be unbiased, inquisitive, receptive, creative, constructive, cooperative, and principled marks the maturity required of any person who would set forth to evaluate the present and to plan the future." (AMA Commission).

As far as the scope of the committee, it is not contemplated that it be an operational committee. Its function would be to study and anticipate future trends, and areas of increased or intensified areas of effort on the part of the various commissions, and to stimulate the various commissions in coordinated directions so there is a cohesiveness to the entire operation of ISMA

Suggested Items for Consideration

A considerable start has been made by the state of Indiana by hiring a firm of consultants to survey our present medical education facilities at the recommendation of ISMA. Recommendations are to be made for future facilities for medical education and personnel required in future years. In a preliminary exposition to the Council in April, it was disclosed that in another ten years we would need to admit double the number of medical students now admitted; that at present time we have only ten interns per 100,000 while the national average is 20 per 100,000. Our present physician population ratio is 24th in the nation and yet we presently educate more of our own physicians than most of the other states. 175 more internships are needed at the present time. A great deal more information will soon be available when the entire report is submitted.

One of the most challenging tasks facing organized medicine today is to find various means to vitalize our county medical societies and to gain much greater participation by the individual members in affairs of their local, district and state associations. We also need to greatly improve our communications between all levels of organized medicine, and to bring an increased awareness of the responsibilities and obligations of

individual members and component societies.

Increased effectiveness of ISMA will require additional full time personnel to staff increased and augmented programs. One of our best means of communication between the local societies and our state association has been the liaison carried out by our field representatives. Unfortunately they are assigned to so many counties that visitation has to be limited. We would benefit greatly by doubling the number and thereby increase the time they have available to spend with county societies.

Some of our best active county societies are the smaller ones, as shown by a survey made in 1963 by our Commission on Special Activities. Many societies are so small that individual committees are not feasible and the society operates as a committee of the whole. A staff member of the AMA wonders if members of smaller societies could not consider joining into regional societies in order to speak in unison with a large membership and in order to possibly afford to employ a full-time staff person to aid in carrying on the affairs of the group.

One of the most serious gaps in our state structure of liaison and a faulty link in the chain of communication is the district society. There is nothing in our constitution that requires membership in a district society, and the duties, perogatives and obligations of a district society are rather indistinct. We recommend that studies be made to delineate how to make the district society a more effective unit in our organization, or to abandon them in favor of some other form of regional society.

We need to have a voice in planning of regional hospitals and other health facilities. We should continue to maintain close liaison with allied and paramedical disciplines. We should make plans for the greatest use of paramedical personnel and have an interest in their training and recruitment, so that we have a full team in the years to come. We must plan on the wisest use and cooperation with such personnel.

President Wood has recently brought attention to further activities which are now available to ISMA, including an increased emphasis in field service, which has already been mentioned; TV programs on medical self-help; assistance to school systems in the field of health education; an active preceptor program; information kits to new members; revitalization of our tape loan library and live TV programs through county medical societies plus the help of available filmstrips and films.

Other items would concern accreditation of nursing homes, projections on increasing medical care costs, further implementation of disciplinary committees, study of the few individuals who persistently overcharge, hospital and physician relationships, future developments in the field of prepaid medical insurance and future arrangements with governmental programs of medical care.

Other items for consideration are the establishment of a residence for retired physicians and an increased effort in establishing postgraduate educational programs which would prove attractive to physicians. The idea of a postgraduate educational cruise has been discussed as one possibility, combining the benefits of good faculty and courses with the pleasure and relaxation of medical fellowship on board an ocean-going or lake cruiser.

MAURICE E. GLOCK, M.D., *Chairman*
M. C. TOPPING, M.D.
PETER PETRICH, M.D.
ALBERT DONATO, M.D.
HERMAN C. ECHSNER, M.D.

REFERENCE COMMITTEE ACTION

Dr. A. E. Stouder, chairman, continued with the report of the Reference Committee on Reports of Officers, as follows:

The committee received with much interest the most excellent report of the Future Planning Committee. Certainly a lot of effort and thought has gone into the making of this report. It is felt that ISMA will want to cooperate and help lead the AMA Commission of Medical Practice in carrying out the intent of this new AMA commission.

The committee recommends that the Future Planning Committee as outlined be made a permanent and regular commission of the ISMA as provided for in Chapter VII of the Bylaws and that an amendment be submitted to the 1965 session amending Section 1 of Chapter VIII of the Bylaws to include such commission.

Mr. President, I move adoption of this section of the report.

(Motion seconded by many, put to vote, and carried.)

The report of the Student AMA activities at I. U. was especially commended as an excellent report and it was felt that the future of Indiana medicine is faced with less awe and fear.

Mr. President, I move adoption of this portion of the report.

(Motion seconded by many, put to vote, and carried.)

Woman's Auxiliary Presidential Address

MRS. JACK E. SHIELDS, Brownstown, president of the Woman's Auxiliary to the Indiana State Medical Association, addressed the House as follows:

The Woman's Auxiliary is proud to be of service to the Indiana State Medical Association. We appreciate the courtesies extended to us by your organization and wish to thank Dr. Wood, Dr. Black, and our advisor, Dr. Everly, for guidance. We also thank Mr. Waggener and the ISMA office staff for their cooperation.

Since this report was given a year ago, we have experienced months of activity within our national theme "Serve and Communicate." Four issues of *The Hoosier Doctor's Wife* have been published and a report has appeared in each issue of *The Journal.* Our April House of Delegates was successful with 165 registered. In June, ten delegates and four alternates attended the convention of the Woman's Auxiliary to the AMA in San Francisco where our theme became "Better Health — Better World"

under the leadership of our national president, Mrs. William H. Evans of Youngstown, Ohio. During the summer our program book was compiled, printed and sent to each county to be used as a guide for auxiliary work. In September, three all-day Area Workshops were held and our program presented to representatives of 36 county auxiliaries. Repeatedly, Indiana has been represented at national conferences and out-of-state conventions.

Legislation has been one of our priority projects with efforts directed toward helping county medical societies with "Operation Hometown." During February, thousands of letters were written to congressmen concerning the King-Anderson bill. Since then, timely letters and telegrams pertaining to current legislation have been sent. Our state legislative chairman is forming a committee of 15 to alert our 60 county auxiliaries when immediate action is indicated. A two-day public speaking seminar and the "Precinct Action Course" are being promoted. A continuing program of education is maintained to acquaint the public with medical legislation and current events in an effort to contribute to the preservation of our free society.

Fifty of our 60 county auxiliaries sold Christmas cards as a fund raising project for AMA-ERF and many sold playing cards and note paper. We emphasized the importance of designating contributions to the AMA Guaranteed Student Loan Fund to which $3,016.71 was given. Our total AMA-ERF contribution was $16,124.85.

The recruitment of capable young people into the medical and paramedical fields has been a continuing service of our auxiliary. Twenty-three counties gave 52 scholarships totaling $10,744.95 and seven counties made ten loans available in the amount of $3,500.00. Fifteen Health Career Days were sponsored and we have 11 active Health Career Clubs. Pamphlets were distributed to high schools to stimulate more interest among the students in health careers.

We have a close relationship with the Indiana Chapter of the Woman's Auxiliary to the Student American Medical Association. Our liaison officer is always ready to give counsel and advice when asked and assists them in setting up budgets and in program planning. This year we are helping to cover expenses of their delegates to their national convention.

More of our auxiliaries are becoming active in the mental health program. A large number participated by giving gifts to patients, working as volunteer workers in mental hospitals, serving on mental health boards and helping to plan meetings for the purpose of educating the public on this problem. Speakers were invited to some of the auxiliary meetings and films were shown to further the education and understanding of our own members. We are hoping to develop more mental health activity within the counties in the coming year.

Indiana gained special recognition nationally this year in the field of International Health Activities. It is heart-warming to know that a total of 25 tons of discarded surgical instruments, medical equipment and supplies were collected, shipped and are now in use around the world.

In the community service projects such as "disaster preparedness," "rural health," and "safety," our prime objective has been education, first indoctrinating our own members who in turn instruct other groups in these educational programs. During the past year our members gave thousands of hours working in "community service."

Our auxiliary accomplishments will become greater in the future due to expanded programs and services at the national level. One of these services is our national publication, the new *Bulletin*, which is now being sent to the 86,125 members. As a result, each of our 2,828 members can be informed and become more helpful to individuals and groups within her community, particularly in the field of medicine and public health.

This is but a brief report of activities in Indiana where our goal is to be of greater service to our auxiliary, to the medical association and to the community. We are growing in number and knowledge, working together for "Better Health in a Better World."

REFERENCE COMMITTEE ACTION

Dr. A. E. Stouder, chairman, presented the following report:

The report of the Woman's Auxiliary was as always an excellent report and very beautifully presented and this committee commends the activities of the auxiliary in behalf of medical practice.

Mr. President, I move adoption of this section of the report.

(Motion seconded by many, put to vote, and carried.)

Mr. President, I move the adoption of this report as a whole.

(Motion seconded by many, put to vote, and carried.)

I wish to thank those who appeared before our committee, especially in the discussion of this item of the Future Planning Committee which will take on the aspects of a commission after the constitutional amendments have been made, and that will be in 1965. I also thank the committee members who served with me.

SECTIONS AND SECTION WORK

Dr. James M. Kirtley, chairman, presented the following report:

No work was assigned to this committee; consequently we have no report.

I move the adoption of this report as read.

(Motion seconded by many, put to vote, and carried.)

MEDICAL EDUCATION AND HOSPITALS

The following matters were referred to the Reference Committee on Medical Education and Hospitals. All reports will be found on the pages indicated in the September, 1964, Vol. 57, No. 9, *Journal* of the Indiana State Medical Association,

with the exception of the supplemental report of the Commission on Medical Education and Licensure and the report of the State Board of Medical Registration and Examination, which are printed below. Resolutions introduced before the House and referred to this committee are printed herewith.

Commission on Medical Education and Licensure (page 1045) and supplemental report.
Commission on Special Activities (page 1045)
State Board of Medical Registration and Examination report
Resolution No. 10 — Authorizing Study of the Results of Treatment by Licensed Psychologists Acting Without Adequate Medical Supervision

Supplemental Report of the Commission on Medical Education and Licensure

To further inform the House of Delegates on the progress of the preceptor program, the commission is attaching a copy of a memorandum which establishes criteria for physicians wishing to act as preceptors.

Since the initial report of the commission, two physicians have been selected as preceptors and as of this date, September 24, 1964, are involved in the program. They are Dr. Malcolm Scamahorn, Pittsboro and Dr. E. L. Hollenberg, Winamac.

MEMO TO: Presidents and Secretaries of component County Medical Societies

FROM: Commission on Medical Education and Licensure, Indiana State Medical Association, Headquarters Office, 3935 North Meridian Street, Indianapolis, Ind.

SUBJECT: Establishment of Preceptor Training Program

For some time the commission has been working on and studying with various people the essential requirements for the establishment of a high quality, practical training program in the area of preceptorships. In recent meetings in cooperation with a faculty representative of the Indiana University School of Medicine, the following plan has evolved. A preceptorship of six week's duration will be offered to the senior medical students as part of their training during the medicine quarter. This program will be elective with the students in lieu of their out-patient medical training.

The qualifications of preceptees will be supervised by the faculty board of the university and the determination of who shall be preceptors throughout the state falls to the local county medical societies with the commission acting as the final determiners.

The question of stipend versus no stipend has been discussed at length and the conclusion reached by the commission members was that this should cover only subsistence since it is a part of the student's formal training and acceptable as such by the university. Such subsistence may be given by the individual preceptors, the county societies and/or local hospital facilities. The entire program is to be organized so that the establishment of a group preceptorship (rather than an individual) in smaller areas with limited numbers of practitioners and hospital facilities *SHOULD NOT BE EXCLUDED.*

The commission members have established the following criteria for preceptors as judged by your societies:

1. Have adequate training and experience.
2. Be licensed to practice in the state of Indiana.
3. Be in good standing with the local and Indiana State Medical Association.
4. Preferably be associated with a hospital and be an active staff member thereof.
5. Be willing to participate on a voluntary basis.
6. Have the approval and recommendation of the county medical society.
7. Be aware that general medicine is the primary field with which we are concerned.
8. Be an individual with community interests (clubs, school, church, etc.)
9. Have an interest in educating students in the diversity of medical practice.
10. Have the ability to transmit material in a concise, logical manner.
11. Have insight to ascertain the success of such transmission.
12. Have the willingness to sacrifice, if necessary, some degree of personal gain to further the program.

There will be an evaluation and review of the program, after inception, by the preceptors, preceptees and the commission.

We sincerely urge your immediate interest and cooperation in discussing among yourselves the participation of such members as you deem would make for a successful program. When such individuals have volunteered to participate we would appreciate the secretaries forwarding to the state office the names of these people, so the final arrangements for establishment of the preceptorship may be undertaken.

This is an effort in which many of us have been interested for many years so let's push hard to its completion.

Peter R. Petrich, M.D., *Chairman*
Commission on Medical Education and Licensure

REFERENCE COMMITTEE ACTION

Dr. Glenn W. Irwin, chairman, presented the following report:

Medical Education

This reference committee commends the work and report of the Commission on Medical Education and Licensure, especially in the area of the preceptorship program. It is hoped that this project will be expanded in the future. Dr. Francis L. Land pointed out that this effort complies with Resolution 68 of the June 1963 meeting of the AMA.

Mr. President, I move the adoption of this portion of the report.

(Motion seconded by many, put to vote, and carried.)

Special Activities

This committee read and accepted the report of the Commission on Special Activities. Unfortunately, the report was brief and no member of the commission was present for comments or questions. This reference committee advises as a general policy that a commission representative be in attendance at all reference committee meetings reviewing the respective commission report.

Mr. President, I move adoption of this section of the report.

(Motion seconded by many, put to vote, and carried.)

Report of Board of Medical Registration and Examination

Number of medical candidates who took the examination*	236
Number of medical candidates who failed the examination*	22
Number of medical candidates who failed in one subject only*	6
Number of medical candidates from foreign medical schools who took the examination	62
Number of medical candidates from foreign medical schools who failed the examination	22
Number of candidates who took the special chiropractic examination	23
Number of candidates who failed the special chiropractic examination	1
Number of candidates who took the regular chiropractic examination	3
Number of candidates who failed the regular chiropractic examination	3
Number of candidates who took the physical therapy examination	4
Number of candidates who failed the physical therapy examination	0
Number of medical applicants granted license in Indiana by endorsement/reciprocity	69
Number of osteopathic applicants granted license in Indiana by endorsement/reciprocity	12
Number of medical applicants who were endorsed to other states	153
Number of osteopathic applicants who were endorsed to other states	2
Number of applicants granted physical therapy license in Indiana by endorsement/reciprocity	9
Number of applicants granted chiropractic license in Indiana by endorsement/reciprocity	8
Number of citations during the year (all physicians)	3
Number of revocations during the year (all physicians)	2
Number of physicians who voluntarily surrendered their Narcotic Stamps to the Internal Revenue Dept., Post Office	2

* Includes foreign graduates, September 28, 1964.

P. T. Lamey, M.D., *Secretary*
Board of Medical Registration and Examination of Indiana

REFERENCE COMMITTEE ACTION

Dr. Glenn W. Irwin, chairman, presented the following report:

There was a lengthy review of the Report of the State Board of Medical Registration and Examination. Fortunately, State Senator James Kirtley, M.D. and President-elect Joe M. Black were in attendance. The main concern of the reference committee was the high incidence of young physicians leaving the state of Indiana. It was felt that members, officers and proper commissions of the ISMA should play an active role in creating new rotating internship programs throughout the state.

Dr. Black felt that hospitals considering or establishing new programs should freely consult with the Indiana University School of Medicine for help and active participation. It was recommended by this reference committee that the Board of Medical Registration and Examination study the reasons why many recent graduates from medical school leave the state. Such a study might help lead to solutions of the problem.

Dr. Francis L. Land stated there was a need for an increase in contact between medical students and physicians in general practice. Dr. M. B. Gevirtz of Hammond stated that his society recommended that the Board of Medical Registration and Examination of Indiana be authorized to approve those physicians who have passed the examination of the National Board of Medical Examiners. This reference committee concurs in this recommendation and recommends that the Legislative Commission draft and sponsor legislation to authorize the Board of Medical Registration and Examination of Indiana to approve, accept and use examinations by the National Board of Medical Examiners.

Mr. President, I move the adoption of this section of this report.

(Motion seconded. This section of the report was discussed by Drs. Michael Shellhouse, Lake county; Stanley Zydlo, Wabash county; William A. Kleifgen, Allen county; Ivan Lindgren, Dearborn county; Thomas Brown, Delaware-Blackford county; Kenneth Olson, St. Joseph county; Wilson Dalton, Shelby county; S. W. Shapiro, Lake county and Robert Hedgcock, Clinton county.)

Dr. Irwin then offered the following change in the last sentence of this section of the reference committee's report:

"This reference committee concurs in this recommendation and recommends that the Legislative Commission study legislation to authorize the Board of Medical Registration and Examination of Indiana to approve and accept examinations by the National Board of Medical Examiners."

(Dr. Irwin's motion for adoption of this amendment to the original report was seconded by many, put to vote, and carried.)

Mr. President, I move the adoption of this portion of the report as amended. **(Motion seconded by many, put to vote, and carried.)**

Resolution No. 10

Introduced by: GRIEVANCE COMMITTEE OF THE INDIANA STATE MEDICAL ASSOCIATION

Subject: RESOLUTION AUTHORIZING A STUDY OF THE RESULTS OF TREATMENT BY LICENSED PSYCHOLOGISTS ACTING WITHOUT ADEQUATE MEDICAL SUPERVISION

WHEREAS, the proponents of licensure for psychologists in Indiana have recently presented the draft of their legislation proposed for 1965 enactment to representatives of the medical profession in Indiana for review, and;

WHEREAS, the effect of similar legislation in other states has been to give a board controlled by psychologists the primary responsibility for answering as to whether or not a member of their profession was practicing within the law or in violation of the respective state's medical practice act, and;

WHEREAS, no evidence has been submitted to representatives of the medical profession in Indiana that boards constituted as described have not in other states supported the treatment of the emotionally ill by psychologists in the absence of adequate medical supervision at consequent risk to the health of the person under treatment, and;

WHEREAS, a need therefore exists to determine the morbidity and mortality experienced in other states where legislation such as proposed for Indiana is already operative;

NOW, THEREFORE BE IT RESOLVED that the results of a study of the effect upon health of such legislation in other states must be made known to the physicians of Indiana before any approval of or support can be given to the proposal to license psychologists in Indiana;

AND BE IT FURTHER RESOLVED, that the president of the ISMA be authorized to appoint a committee of five (5) psychiatrist members of the ISMA to study and report before October 1, 1965 the effect upon health of the type of legislation in question as it has actually operated in at least five (5) other states of the United States and the president of the ISMA be further authorized to invite the president of the Indiana Psychological Association to name one (1) member of that organization and to invite the president of the Indiana Association for Mental Health to name one (1) non-professional member each of whom will act as a consultant to the ISMA committee. In the event such a consultant is not so named, an invitation shall be addressed to the administration of Indiana University asking that a faculty member be invited to fill either of or both of these advisory posts.

REFERENCE COMMITTEE ACTION

Dr. Glenn W. Irwin, chairman, presented the following report:

The committee read and approved Resolution No. 10.

Mr. President, I move the adoption of this portion of the report.

(Motion seconded, put to vote, and carried.)

Dr. Glenn W. Irwin, chairman, continued with the report of the Reference Committee on Medical Education and Hospitals:

This committee wishes to delete the last paragraph of this report, and refer it to the Commission on Medical Education and Licensure since this commission has several similar items and recommendations. This last paragraph reads as follows:

The remaining matter referred to this reference committee was receipt of a letter from Dr. P. M. Inlow, secretary-treasurer of the Shelby County Medical Society stating the following: "We recommend that the Shelby County Medical Society endorse the Indiana University general practice preceptor plan. We further recommend that the society forward to the Indiana University Preceptorship Committee this endorsement with the understanding that we will make arrangements to offer a worthwhile program in our county for one or two students. We will welcome any suggestions from the I. U. committee, and we believe that we can offer a profitable experience for the student." James H. Tower, Jr., M.D. and Roger R. Whitcomb, M.D.

Mr. President, I move the adoption of this section of the report as amended.

(Motion seconded, put to vote, and carried.)

Mr. President, I move the adoption of this report as a whole, as amended.

(Motion seconded by many, put to vote, and carried.)

LEGISLATION

The following matters were referred to the Reference Committee on Legislation. All reports will be found on the pages indicated in the September, 1964, Vol. 57, No. 9, *Journal* of the Indiana State Medical Association. Resolutions introduced before the House and referred to this committee are printed herewith.

Commission on Legislation (pages 1033-34)
Resolution No. 2 — Control of Drug Therapy
Resolution No. 3 — Control of Blood Banks
Resolution No. 7 — Privileged Information
Resolution No. 8 — Legislation to Establish Standards of Quality for Optical Lenses

REFERENCE COMMITTEE ACTION

Dr. Frank H. Green, chairman, presented the following report:

First considered was the report of the Commission on Legislation which is on pages 154 to 156 of the Handbook. This was accepted as written with the recommendation of the committee to the Commission on Legislation that because of the ads which are to appear in the newspapers throughout the state advising the people in those areas to call their physicians about the Kerr-Mills Bill, it is our recommendation that the Legislative Commission see that all current information concerning the

Kerr-Mills Bill be sent out to all of the doctors in the state so that they may have the answers for the patients who call as a result of these newspaper ads. It is the committee's recommendation that this information be prepared in a condensed form so that it may be available for the local doctors. This should cover the pertinent questions which we might expect from our patients.

We recommend the report of the Commission on Legislation be adopted with the additional recommendations suggested, and I so move the adoption of this section.

(Motion duly seconded, put to vote, and carried.)

Resolution No. 2

Introduced by: VANDERBURGH COUNTY MEDICAL SOCIETY

Subject: CONTROL OF DRUG THERAPY

WHEREAS, the public should have protection from harmful effects of medications and therapeutic agents, and,

WHEREAS, every physician is entitled to full and prompt disclosure of all limitations, side-effects, hazards and complications related to the use of therapeutic and diagnostic agents, and,

WHEREAS, the creative efforts of pharmaceutical organizations in providing new or improved products should not be hampered by unnecessary restrictive regulations, and,

WHEREAS, the practicing physicians must be allowed some latitude of judgment in the drug treatment of serious diseases where (frequently the more) potent or potentially toxic drugs may be necessary for the proper treatment of these diseases, now,

THEREFORE, BE IT RESOLVED, that the Vanderburgh County Medical Society urge the development of a reasonable and fair program with the FDA to insure equitable protection of all those whose interests are involved, and to insure that the medical profession will retain greater control and influence in the handling of drug therapy, and,

BE IT FURTHER RESOLVED, that techniques be formulated to provide alert recognition of risks by the medical and pharmaceutical professions, and on the other hand, to avoid undue alarm on the part of the public at large,

BE IT FURTHER RESOLVED, that the AMA be urged to expand its facilities to whatever degree is required to implement these objectives.

REFERENCE COMMITTEE ACTION

Dr. Frank H. Green, chairman, presented the following report.

Resolution No. 2. *Control of Drug Therapy.* It is the recommendation of this committee that this be adopted as written.

I so move that this report be adopted.

(Motion duly seconded and carried on a standing vote.)

Resolution No. 3

Introduced by: FORT WAYNE MEDICAL SOCIETY

Subject: CONTROL OF BLOOD BANKS

WHEREAS, the medical profession has the primary responsibility for the care and treatment of patients, and,

WHEREAS, the procurement, storage, processing and administration of blood is part of the practice of medicine, and,

WHEREAS, a blood bank is a medical facility and the director must be a doctor of medicine, and,

WHEREAS, the responsibility of blood banking procedures can best be discharged by medical societies at the local level, and,

WHEREAS, it is highly essential that the organization of new blood banking programs, and the modification of existing ones should have, in the interest of public health and safety, the approval of the county medical society.

BE IT THEREFORE RESOLVED, by the House of Delegates of the Indiana State Medical Association that it favors enactment of legislation by the Indiana State Legislature to the effect that all blood banks must operate subject to the approval of the county medical society in which said blood bank is located, and,

BE IT FURTHER RESOLVED, that approval of new blood banks or modification of existing ones be subject to approval of the local county medical society, and,

BE IT FURTHER RESOLVED, that, at the appropriate time the position of the Indiana State Medical Association be made known to the members of the State Legislature, and,

BE IT FURTHER RESOLVED, that a representative of the Indiana State Medical Association appear before a committee of the State Legislature to which this resolution, or a similar resolution, be referred and to urge its enactment by the legislature of the state of Indiana.

REFERENCE COMMITTEE ACTION

Dr. Frank H. Green, chairman, presented the following report:

Resolution No. 3 — *Control of Blood Banks.* It is the recommendation of this committee that this be adopted as written. I so move that this report be adopted.

(Motion seconded by many, put to vote, and carried.)

Resolution No. 7

Introduced by: FORT WAYNE MEDICAL SOCIETY

Subject: PRIVILEGED INFORMATION

WHEREAS, medical studies of conditions causing death and disability are an important means of protecting the health of the public, and;

WHEREAS, medical studies provide information which can be used in the prevention and control of disease, and;

WHEREAS, this material provides an excellent source of teaching material, and;

WHEREAS, this information can be more readily secured and utilized in advancing the cause of good health for the public if it is confidential

with regard to persons whose condition or treatment has been studied;

THEREFORE, BE IT RESOLVED, that the Indiana State Medical Association appear before the appropriate committee of the state legislature to urge the enactment of the attached bill relative to privileged information.

A Bill

FOR AN ACT relating to public health and welfare; to provide for confidential information received by the Indiana State Board of Health, Indiana State Medical Association, allied medical societies, in-hospital staff committees, or local health departments, in the course of a medical study for the purpose of reducing morbidity or mortality; to provide that such information and material so furnished may be used only for the purpose of advancing medical research and medical education; to provide for general publication of a summary of said studies; to provide an exemption from legal liability for those furnishing such information and for those studying and publishing the results and summaries of such studies; and to provide that such material and information and any findings or conclusions of such authorized groups shall be privileged communications which may not be used or offered or received in evidence in any legal proceeding.

Be it enacted by the people of the State of Indiana,

Section 1. Any person, hospital, sanitorium, nursing or rest home or other organization may provide information, interviews, reports, statements, memoranda, or other data relating to the condition and treatment of any person to the State Board of Health, the Indiana State Medical Association or any of its allied medical societies, any in-hospital staff committee, or local health department, to be used in the course of any study for the purpose of reducing morbidity or mortality, and no liability of any kind or character for damages or other relief shall arise or be enforced against any person or organization by reason of having provided such information or material, or by reason of having released or published the findings and conclusions of such groups to advance medical research and medical education, or by reason of having released or published generally a summary of such studies.

Sec. 2. The State Board of Health, the Indiana State Medical Association or any of its allied medical societies, any in-hospital staff committee, or local health department, shall use or publish said material only for the purpose of advancing medical research or medical education in the interest of reducing morbidity or mortality, except that a summary of such studies may be released by any such group for general publication. In all events the identity of any person whose condition or treatment has been studied shall be confidential and shall not be revealed under any circumstances.

Sec. 3. All information, interviews, reports, statements, memoranda, or other data furnished by reason of this act and any findings or conclusions resulting from such studies are declared to be privileged communications which may not be used or offered or received in evidence in any legal proceeding of any kind or character, and any attempt to use or offer any such information, interviews, reports, statements, memoranda or other data, findings or conclusions or any part thereof, unless waived by the interested parties, shall constitute prejudicial error resulting in a mistrial in any such proceeding.

REFERENCE COMMITTEE ACTION

Dr. Frank H. Green, chairman, presented the following report:

Resolution No. 7 — *Privileged Information.* This resolution was discussed by the committee and its adoption recommended with the exception that the resolution following the whereas clauses be modified to read as follows:

"THEREFORE, BE IT RESOLVED, that the Indiana State Medical Association appear before the appropriate committee of the State Legislature to urge the enactment of the legislation to carry out said purposes."

This modification is recommended for the reason that the bill attached in the resolution does not meet the Indiana requirements for bill drafting and overlaps other laws and so as to give the Legislative Commission and Council the opportunity to draft a bill which would meet Indiana requirements.

We recommend the adoption of this amendment to Resolution No. 7 as read.

(Motion seconded, put to vote, and carried.)

I move the adoption of Resolution No. 7 with the amendment as adopted.

(Motion seconded, put to vote, and carried.)

Resolution No. 8

Introduced by: ST. JOSEPH COUNTY MEDICAL SOCIETY

Subject: LEGISLATION TO ESTABLISH STANDARDS OF QUALITY FOR OPTICAL LENSES

WHEREAS, at the present time, there are no legislative required standards for the quality of optical glass nor optical lenses in the state of Indiana, and

WHEREAS, many times inferior quality glass is used for optical lenses because there are no standards of control, and

WHEREAS, it is difficult for ophthalmologists and optometrists to determine inferior optical lenses without specialized equipment, and

WHEREAS, the people of Indiana are, in most instances paying for and are entitled to receive first quality optical lenses which without proper standards adequately controlled may not be true, and

WHEREAS, in order to protect the public it is essential that standards of quality for optical lenses be established by legislative action,

NOW, THEREFORE BE IT RESOLVED, That the St. Joseph County Medical Society go on record

as favoring legislation in the state of Indiana which will establish a standard of quality for optical lenses, and

BE IT FURTHER RESOLVED, That a copy of this resolution be presented by the delegates of the St. Joseph County Medical Society to the Indiana State Medical Association House of Delegates at their 1964 annual meeting with the recommendation that the Indiana State Medical Association present a standardization of optical lenses bill to the next session of the Indiana State Legislature, and

BE IT FURTHER RESOLVED, That the Indiana State Medical Association be urged to take every step possible to get such legislation approved.

REFERENCE COMMITTEE ACTION

Dr. Frank H. Green, chairman, presented the following report:

The committee considered resolution No. 8, *Legislation to Establish Standards of Quality for Optical Lenses*. We recommend the adoption of this resolution as presented, and I so move.

(Motion duly seconded, put to vote, and carried.)

We recommend the adoption of the report of the Reference Committee on Legislation as amended and move its adoption as amended.

(Motion seconded, put to vote, and carried.)

Mr. President, we move the adoption of this report as a whole, as amended.

(Motion seconded by many, put to vote, and carried.)

I wish to thank those who appeared before our committee, my committee members and the members of the House of Delegates for their indulgence.

PUBLIC RELATIONS

The following matters were referred to the Reference Committee on Public Relations. All reports will be found on the pages indicated in the September, 1964, Vol. 57, No. 9, *Journal* of the Indiana State Medical Association.

Grievance Committee (pages 1030-31)
Commission on Public Information (pages 1034-36)
Commission on Inter-Professional Relations (pages 1044-45)
Commission on Aging (page 1046)

REFERENCE COMMITTEE ACTION

Dr. M. C. Topping, chairman, presented the following report:

Grievance Committee

The Grievance Committee submitted a statistical review of their work during the past year and of the methods used during the past five years. It is unfortunate that the nature of their work limits the publication of the details of their investigative procedures and of the results of their efforts in each instance. For this reason the committee considers that much more work has been done than is reflected in this report.

The Grievance Committee then directs the attention of the association to the quasi-legal practices of some persons in this state in attempting to diagnose or treat emotional or mental illness by so-called counselling, psychotherapy or whatever.

It is the opinion of your committee, supported by unanimous testimony, that psychotherapy is a part of the practice of medicine. We further recommend the adoption of Resolution No. 10 given by the Grievance Committee in support of this opinion, which incidentally you have already adopted.

Mr. President, I move the adoption of this portion of the report.

(Motion duly seconded, put to vote, and carried.)

Public Information

The Commission on Public Information reports on ten different projects for the year past and makes 14 recommendations for the implementation of medical journalism awards.

The reference committee wishes to commend this commission particularly for their work in the distribution of debate kits to the more than 700 high schools in the state. We found on inquiry to the several doctors attending our meeting, that there was little general knowledge of this activity among the doctors and suggest that this lack of communication be corrected by informing the doctors by letter or through other available media of these and like projects as they are presented to the public.

We also commend the commission on their efforts in making available the television series on "Doctors at Work" and trust that funds for putting this series on the air may soon be available.

It is suggested that the county societies which have not already done so, make every effort to obtain local radio time for "public service" programs.

Each of the other eight projects of the commission was reviewed and completely concurred in by this committee. The 14 recommendations of the commission for programming a journalism award were studied and their adoption is urged.

We again wish to compliment this commission on their thoroughness in such a wide scope of activities. There is a tremendous amount of work encompassed in this report.

Mr. President, I move the adoption of this portion of the report.

(Motion seconded, put to vote, and carried.)

Inter-Professional Relations

The Commission on Inter-Professional Relations reports the discussion of a physician-pharmacist code of understanding and the adoption of such a code by the commission. It is the opinion of this committee that a commission of the state association may not adopt a code for the association, which would be a policy making decision. It is assumed therefore that the commission is recommending to the House of Delegates that a "Code of Understanding for Physicians and Pharmacists" be adopted by the medical and pharmaceutical professions of this state.

This committee recommends that a sub-committee of this Commission on Inter-Professional Relations be appointed to work with a committee from

the state Pharmaceutical Association to formulate such a code for presentation to the next regular meeting of the House of Delegates. A copy of such a code as established in the state of Texas is appended for their consideration.

This committee concurs with the recommendation of the commission that labeling of all prescriptions would be undesirable.

We also wish to commend the commission for their efforts in improving liaison with hospital administration and nursing staffs, also in the promotion of better medical and religious relations in the communities served by the local county societies.

Mr. President, I move the adoption of this portion of the report as amended.

(Motion duly seconded, put to vote, and carried.)

Commission on Aging

The Commission on Aging submitted an excellent report with which this committee agreed in toto. We would like to add our endorsement to the recommendations of the commission that added emphasis on gerontology be given in the Indiana University School of Medicine.

Mr. President, I move the adoption of this portion of the report.

(Motion seconded, put to vote, and carried.)

Mr. President, I move the adoption of the report as a whole.

(Motion seconded by many, put to vote, and carried.)

I wish to thank the members who testified before this committee and to the working members of the committee, Drs. Bryan, Wilson and Bechtold.

HYGIENE AND PUBLIC HEALTH

The following matters were referred to the Reference Committee on Hygiene and Public Health. All reports will be found on the pages indicated in the September, 1964, Vol. 57, No. 9, *Journal* of the Indiana State Medical Association with the exception of the Maternal Mortality Study report, copy of which was handed to each delegate, and the supplemental report of the Commission on Voluntary Health Agencies, which is printed herewith.

Commission on Public Health (pages 1038-40)
Commission on Voluntary Health Agencies (pages 1040-42), and supplemental report
Maternal Mortality Study report (copy handed to each delegate)

REFERENCE COMMITTEE ACTION

Dr. Dean B. Jackson, chairman, presented the following report:

Public Health

The Public Health Committee recommends adoption of the report of the Commission on Public Health as written and wishes to commend the commission on their continued excellent work, especially pertaining to Junior-Senior Day.

For the purpose of emphasis, the reference committee reminds the House of Delegates that the 1965 meeting of the Indiana State Medical Association will be held in conjunction with the American Medical Association's Council on Occupational Health.

The committee also recommends that the report of Rural Health and Physicians Placement which has successfully encouraged settlement of physicians in smaller communities by the Junior-Senior Day be brought to the attention of the Council on Rural Health of the AMA by the Indiana delegation and that this be further brought to the attention of the National Rural Health Conference.

Mr. President, I move the adoption of this portion of the report.

(Motion duly seconded, put to vote, and carried.)

Supplemental Report of Commission on Voluntary Health Agencies

The National Foundation announced, as of September 1, 1964, that they are dropping arthritis as one of their disease areas of emphasis. The American Rheumatism Association has been formed and the former director of the medical department of the National Foundation, Dr. William S. Clark, has become president of this new organization. The National Foundation appears to be moving towards greater participation by physicians in their policy making; however, no permanent replacement for Dr. Clark has been named by the National Foundation.

The Council on Voluntary Health Agencies of the AMA has published a new Directory of National Voluntary Health Agencies with up-to-date policies of the AMA as an introduction.

The AMA held the first National Voluntary Health Conference in Chicago, September 17-18, 1964. This conference was highly successful and every national agency was represented. The fact that came out of the discussion groups of the greatest interest in Indiana was the obvious desire by all participating for a Joint National Accreditation Board for Voluntary Health Agencies with the National Health Council being the organization mentioned most often as the vehicle. This is a sweeping conclusion in favor of the plans proposed by the Indiana State Medical Association in two preceding years. This was not previously favored by the AMA. It should be pointed out that this would be a joint accrediting board, in which the AMA would probably join other groups to accredit the national agencies in this field.

The national conference also brought out the intense appreciation of the voluntary health agencies for the fact that organized medicine is moving towards increased participation and leadership in that field, and this leadership is being sought and used. Similar participation at state and local level was urged.

All of these points, plus others developed at the national conference, point to the fact that the goals of the Indiana State Medical Association in the field of voluntary health agencies are becoming realities as a national practice. This will mean even greater efforts on the part of your Commission on Voluntary Health Agencies of the Indiana State Medical Association and these activities

should attract the attention and support of every member of the Indiana State Medical Association.

Your commission recommends that some more effectual means of disseminating the information from this commission to the members be developed.

Norman R. Booher, M.D., *Chairman*

REFERENCE COMMITTEE ACTION

Dr. Dean B. Jackson, chairman, presented the following report:

Voluntary Health Agencies

The committee recommends state-wide distribu- report of the Commission on Voluntary Health Agencies and the supplemental report of the Commission on Voluntary Health Agencies and wish to extend commendations to the members for their arduous work and I so move.

(Motion duly seconded, put to vote, and carried.)

The committee recommends state-wide distribution of the AMA Directory of National Voluntary Health Organizations to all members and that mailing expense be authorized if required.

Mr. President, I move the adoption of this recommendation.

(Motion duly seconded, put to vote, and carried.)

Maternal Mortality Study

Finally, the committee recommends adoption of the Maternal Mortality Study report, and I so move.

(Motion duly seconded, put to vote, and carried.)

In conclusion I wish to thank the members of the association who appeared before our reference committee, and especially Dr. Norman Booher and Dr. Forrest Babb and also the members of the reference committee who served with me.

Mr. President, I move the adoption of this report as a whole.

(Motion seconded by many, put to vote, and carried.)

AMENDMENTS TO CONSTITUTION AND BYLAWS

The following matters were referred to the Reference Committee on Amendments to Constitution and Bylaws. All reports will be found on the pages indicated in the September, 1964, Vol. 57, No. 9, *Journal* of the Indiana State Medical Association. Resolutions introduced before the House and referred to this committee are printed herewith.

Commission on Constitution and Bylaws (page 1033)

Resolution No. 1 — Professional Relations Between Doctors of Osteopathy and Doctors of Medicine

Resolution No. 4 — Transfer of Newton County Medical Society from the Tenth District to the Ninth District

Resolution No. 5 — Creation of Section on Pathology

REFERENCE COMMITTEE ACTION

Dr. Maurice E. Glock, chairman, presented the following report:

Your Reference Committee on Amendments to the Constitution and Bylaws met at nine a.m., October 13, 1964. All members were present.

Report of Commission on Constitution and Bylaws

The first item of business was the report of the Commission on Constitution and Bylaws (pages 153 and 154 in the Handbook.) After considerable discussion paragraph (1) was amended by striking out the words in lines 10 and 11 "with one hundred and fifty copies thereof" and inserting the words after "House" in line 21: "*and each delegate shall be furnished a copy before the next meeting of the House.*" Paragraph (1) will then read:

BE IT RESOLVED, that Section 7, Chapter IV, of the Bylaws be amended as follows: delete the second paragraph of said Section, which reads as follows: "Provided, that this sub-section of the Bylaws may be suspended with respect to any resolution upon a two-thirds majority vote of the House of Delegates," and substitute in lieu thereof the following: "Provided, that where a resolution has been first submitted to the Committee on Rules and Order of Business together with a written statement setting forth the reasons why said resolution was not mailed to the executive secretary more than 45 days prior to the meeting of the House of Delegates and also setting forth in said written statement the reason why said resolution is of such an emergency nature that it cannot wait until the next meeting of the House, and said Committee on Rules and Order of Business has approved said resolution for submission to the House, and each delegate shall be furnished a copy before the next meeting of the House, then this sub-section of the Bylaws may be suspended with respect to said resolution upon a two-thirds vote of the House of Delegates."

I move the above amendments to the commission report be accepted.

(Motion seconded, put to vote, and carried.)

I move that paragraph (1) of the commission report as amended be adopted.

(Motion seconded, put to vote, and carried.)

Paragraph (2) of the report is approved and with the changes submitted, Chapter IV, Section 5, will now read, "Proposals calling for appropriations of funds by the House of Delegates shall be submitted to the *Executive Committee and* the Council for their recommendation before final action of the House.

Paragraph (3) was accepted as submitted.

Paragraph (4) is in conflict with the Constitution, Article IX, Section 8 (page 199) of the Handbook, and your reference committee recommends that the words, "until the next meeting of the House of Delegates" be deleted and the words substituted, "*until a new Treasurer be elected.*"

I move the foregoing amendment be approved.

(Motion seconded by many, put to vote, and carried.)

I move the adoption of paragraph (3), and paragraph (4) as amended.

(Motion duly seconded, put to vote, and carried.)

The Commission on Constitution and Bylaws is commended for an excellent report and I move the report as a whole as amended be adopted.

(On roll call vote of 104 to 0, the report of the Reference Committee on Amendments to Constitution and Bylaws as amended was adopted.)

Resolution No. 1

Introduced by: VANDERBURGH COUNTY MEDICAL SOCIETY

Subject: PROFESSIONAL RELATIONS BETWEEN DOCTORS OF OSTEOPATHY AND DOCTORS OF MEDICINE

WHEREAS, the adoption of criteria for determining the propriety of professional relations between doctors of osteopathy and doctors of medicine has been entrusted to the state medical associations by the American Medical Association, and,

WHEREAS, the Indiana State Medical Association has no formal basis upon which an individual physician may establish his decision to have such relations with an osteopath except upon his personal judgment based on general guide lines, and,

WHEREAS, some formal technique in making such a determination in a given locality would be helpful to all of the physicians concerned, and,

WHEREAS, this would most likely be carried out with the greatest justice and fairness on a regional or a county level, and,

WHEREAS, specific programs for doing this could be done with the facilities already available in organized medicine and based upon the general principles already accepted by the AMA,

NOW THEREFORE BE IT RESOLVED that the ISMA Commission on Inter-Professional Relations be entrusted with formulating a definite program whereby a county medical society (or societies) may determine which osteopaths qualify for professional relations on an ethical basis, and,

BE IT FURTHER RESOLVED that the Council of ISMA be authorized to adopt such recommendations of the commission until the next meeting of the House of Delegates.

REFERENCE COMMITTEE ACTION

Dr. Maurice E. Glock, chairman, presented the following report:

Next considered was Resolution No. 1 — *Professional Relations between doctors of osteopathy and doctors of medicine* (pages 89 and 90, Handbook.) This was freely discussed by several attending the reference committee hearing and by the members of the reference committee. Your reference committee felt that if this resolution were to be adopted, it should be changed to have the Commission on Inter-Professional Relations report to the House of Delegates at the next annual meeting. Therefore, we recommend that the resolution be amended to read,

"NOW THEREFORE BE IT RESOLVED that the ISMA Commission on Inter-Professional Relations be entrusted with formulating a definite program whereby a county medical society (or societies) may determine which osteopaths qualify for professional relations on an ethical basis, and make a report to the next annual meeting of the House of Delegates."

We also recommend that the final paragraph, "BE IT FURTHER RESOLVED . . . " be deleted.

I move the acceptance of the above amendment to Resolution No. 1.

(Motion duly seconded, put to vote, and carried.)

I move the adoption of Resolution No. 1 as amended.

(Motion seconded by many, put to vote, and carried.)

Resolution No. 4

Introduced by: NEWTON COUNTY MEDICAL SOCIETY

Subject: TRANSFER OF NEWTON COUNTY MEDICAL SOCIETY FROM THE TENTH DISTRICT TO THE NINTH DISTRICT

WHEREAS, the Newton County Medical Society is in the Tenth District, and

WHEREAS, the shopping habits of the doctors' families are directed southward, and

WHEREAS, the division of time between Eastern and Central Standard Time is in Newton County, and

WHEREAS, the mode of living is more in keeping with the Ninth District, and

WHEREAS, the doctors of Newton County voted to be transferred to the Ninth District,

THEREFORE BE IT RESOLVED, with these things in mind, the Newton County Medical Society be transferred from the Tenth District to the Ninth District.

REFERENCE COMMITTEE ACTION

Dr. Maurice E. Glock, chairman, presented the following report:

Next item considered was Resolution No. 4, *Transfer of Newton County Medical Society From the Tenth District to the Ninth District.* This was discussed by a member of the Newton County Medical Society who pointed out that the five members of their society send their patients to hospitals in Lafayette and do not have like interests of other members of the Tenth District, who practice in an industrial community, whereas Newton County is a rural farming community. A member of the Lake County Medical Society confirmed these statements. However, this will require an amendment of Chapter XXVII, Section 2 of the Bylaws, which amendment would have to lay on the table for one day under Chapter XXXII of the Bylaws, which can not be done at this session. We therefore recommend that in lieu of said resolution, the Commission on Constitution and Bylaws be directed to prepare such an amendment to Sec. 2 of Chapter XXVII of the Bylaws for submission at the next session of the House.

Mr. President, I move the adoption of this section of the report.

(Motion duly seconded, put to vote, and carried.)

Resolution No. 5

Introduced by: LESTER H. HOYT, M.D., delegate, Marion County

Subject: CREATION OF SECTION ON PATHOLOGY

WHEREAS, the Indiana Association of Pathologists is composed of in excess of 80 active members who are members of their component county medical societies and the Indiana State Medical Association, and

WHEREAS, these members have met almost annually for a luncheon during the annual convention of the Indiana State Medical Association, and

WHEREAS, they have and will take active part in the scientific portion of the annual convention, and

WHEREAS, the members of the Indiana Association of Pathologists at their annual meeting in 1963 approved requesting formulation of a section of the association — a Section on Pathology — in accordance with Article VII of the Constitution of the Indiana State Medical Association and under Chapter III, Section 1 of the Bylaws of the association,

THEREFORE BE IT RESOLVED: That a Section on Pathology be hereby approved and provided for by amendment of Chapter III, Section 1 of the Bylaws.

REFERENCE COMMITTEE ACTION

Dr. Maurice E. Glock, chairman, presented the following report:

Resolution No. 5 provides for an amendment to Chapter III, Section 1, of the Bylaws by adding thereto a *Section on Pathology*. This resolution was discussed by Dr. Lester Hoyt. There was agreement that such a section would not detract from the state meeting and might serve as an added inducement for pathologists to attend the annual meeting. Your reference committee approved Resolution No. 5.

I move the adoption of this resolution and said amendment to said Section 1 of Chapter III of the Bylaws.

(Motion seconded by many, put to vote, and carried.)

At this time I would like to thank those who appeared before the reference committee and were quite helpful. I'd like to thank also the members of the committee, Drs. Olson, Mericle, Lee and Fessler.

I move the adoption of this report as a whole.

(Motion seconded, put to vote, and carried.)

MISCELLANEOUS BUSINESS

The following matters were referred to the Reference Committee on Miscellaneous Business. All reports will be found on the pages indicated in the September, 1964, Vol. 57, No. 9, *Journal* of the Indiana State Medical Association, with the exception of the supplemental report of the Committee on Student Loan, the supplemental report of the Commission on Governmental Medical Services, the supplemental report of the chairman of the Council, and the Building Committee report, which are printed below. Resolutions introduced before the House and referred to this committed are printed herewith.

Committee on Student Loan (pages 1031 and 1032), and supplemental report

Commission on Convention Arrangements (no printed report)

Commission on Governmental Medical Services (pages 1036-1038), and supplemental report

Building Committee Report

Resolution No. 6 — Dues of Indiana State Medical Association

Resolution No. 9 — Nomination of Dr. Wood for President-elect of AMA

President's Address — remarks concerning financial matters

Council recommendation.

REFERENCE COMMITTEE ACTION

Dr. Eugene F. Senseny, chairman, presented the following report:

Your Reference Committee on Miscellaneous Business considered the following items which were referred to it:

Convention Arrangements

Your Committee on Miscellaneous Business wishes to commend very highly the Commission on Convention Arrangements for their excellent performance. Both the scientific program and scientific exhibits were without parallel.

Mr. Chairman, this reference committee recommends the adoption of this commendation by the House as an expression of sincere thanks to those devoted people who developed this convention.

Mr. President, I move the adoption of this section of the report.

(Motion seconded by many, put to vote, and carried.)

Governmental Medical Services

The committee next considered the report of this commission. The chairman of the commission augmented this report by testifying on each section of the report.

a. the educational portion of the Medical Self-Help program which would require funding to cost $6,800.00.

Section 3 of the report presents a new fee schedule for the Veterans' Hometown Care Program. It has been upgraded.

Section 4 of the report deals with the liaison committee on veterans' affairs and augments the idea of care primarily for a service-connected disability.

This reference committee is basically in accord with this commission's report. Mr. President, I move the adoption of this section of the report.

(Motion seconded by many, put to vote, and carried.)

Supplemental Report of Commission on Governmental Medical Services

Dr. Charles R. Alvey, chairman, presented the

following supplemental report:

Resolution No. 5 (1963) regarding medical director in Department of Corrections was introduced by the LaPorte County Medical Society and after consideration before its reference committee it was referred to the Commission on Governmental Medical Services, a special sub-committee was appointed to study this problem.

On January 30, 1964, after some delay in communication between our office and the Governor's office, and back, a meeting was held by the committee with Governor Welsh and Mr. Arthur Campbell, Director of the Department of Corrections. The situation was discussed and both state representatives expressed the feeling that help was badly needed and welcomed the services of the Indiana State Medical Association.

On February 19, 1964 a meeting was held with Mr. Campbell and all of the heads of the penal institutions in the state of Indiana. General problems were discussed and each institutional head was asked to present his medical situation and personnel problems. These were many and varied as would be expected.

The next step was a visitation to the institutions and four of the six have been visited to observe the problem at first hand.

The following recommendations are presented to you for your approval:

1. The establishment of the position of medical director in the state office of corrections, this to be a doctor of medicine who will supervise health activities in the state correctional institions.
2. That the institutional heads utilize local practitioners facilities when available as this is permissible by law.

The following resolution is presented to implement the suggestions.

WHEREAS, a resolution was presented in the 1963 House of Delegates regarding a medical director for the Department of Correction, State of Indiana, and;

WHEREAS, a committee was appointed and has made a thorough study of this problem, and;

WHEREAS, the committee has presented recommendations pertinent to this problem;

BE IT RESOLVED, that the House of Delegates of the Indiana State Medical Association do recommend to the Governor of Indiana that the position of medical director, Department of Corrections be created, and,

BE IT FURTHER RESOLVED, that this shall be done at the earliest possible moment, and

BE IT FURTHER RESOLVED, that a copy of the supplemental report of the Commission on Governmental Medical Services and of this resolution be forwarded immediately to Governor Welsh, Mr. Arthur Campbell and others as deemed necessary for their information and action.

REFERENCE COMMITTEE ACTION

Dr. Eugene F. Senseny, chairman, continued with the report of the Reference Committee on Miscellaneous Business:

Considered separately, this supplemental report, of which you all have a copy, ends with a resolution which was developed after a year's study and asks specifically for a medical director in the State Department of Corrections, that he be a physician and employed on a civil service basis, and, further, that institutional heads use local facilities when possible.

The committee further recommends that this resolution be referred to the Commission on Legislation for augmentation during the next session of the state legislature.

Mr. President, I move the adoption of this section of the report.

(Motion seconded by many, put to vote, and carried.)

Now, I move for adoption of the report as a whole.

(Motion seconded by many, put to vote, and carried.)

President's Address, Resolution No. 6, and Recommendation of the Council

Resolution No. 6

Introduced by: FOUNTAIN AND WARREN COUNTY MEDICAL SOCIETY

Subject: DUES OF INDIANA STATE MEDICAL ASSOCIATION

WHEREAS, the Indiana State Medical Association has given extensive service, both obvious and subtle, to its members in the past and,

WHEREAS, the need for broadening these services and intensifying activity on various levels is great and,

WHEREAS, an increase in services to any organization requires an increase in the financial expenditures of that group,

NOW THEREFORE BE IT RESOLVED by this House of Delegates that there be a change in the dues structure of the Indiana State Medical Association providing for a $10.00 increase in 1965 and a $5.00 annum increase in 1966 and 1967, said increase being allocated to the General Fund.

Council Recommendation

Dr. K. O. Neumann, chairman of the Council, presented the following recommendation:

On August 30th the officers of your association, as well as the officers of county medical societies, and each delegate heard a report from the president of the association which has since been mailed to every physician in the state of Indiana. As a result of this and of other factors, your Council received a report from the Executive Committee. The Executive Committee has made an extensive study of the financial position of the association and has reviewed most carefully the president's comments of August the 30th, as well as those which were made this evening.

Your Council received the recommendation from the Executive Committee and we, in turn, recommend to this House of Delegates that we feel a dues increase of $25.00 per year is essential at this time. The Council likewise has reviewed carefully the

financial structure of the association and has been aware over the years past that in attempting to keep pace with the expanded programs and inflationary costs, our reserves have been depleted of approximately $148,000.00 over a period of years.

We have made a strenuous effort to conduct the association in its activities without requesting an increase in dues but with inflation and increasing demands, it is essential that we face the facts and at this time provide the funds necessary to carry on the program which is expected of this association. We therefore recommend to this House of Delegates that they approve, beginning with the year 1965, a dues increase of $25.00 per year.

REFERENCE COMMITTEE ACTION

Dr. Eugene F. Senseny, chairman, presented the following report:

Your committee had that portion of the presidential address regarding financial matters referred to it. Also referred to the committee was Resolution No. 6 of the Fountain-Warren County Medical Society, calling for an *increase in the annual dues of the association.* Inasmuch as these matters dealt with the same subject, we considered them together. The president's recommendations can best be considered by listing the suggested expansion and activities as listed in the presidential address.

$16,000.00 for two additional secretaries and one additional staff man

$5,000.00 for television programs

$10,000.00 for the contingency fund to implement commission and committee projects or programs

$1,000.00 for expanding public education

$6,000.00 for emergency call service information

$376.75 for cabinets and addressograph plates

$6,611.35 for the purchase of an addressograph

$5,923.90 for the purchase of a printing press, the installation, and to include training of personnel

5% cost of living increase for headquarters personnel (12 employees) which will amount to approximately $3,500.00.

This totals $54,411.50.

In testimony offered by members of the Executive Committee, the chairman of the Council, our treasurer and our president, shows us that our deficit as of December 31, 1964, will be $46,000.00. This, plus the expenditures outlined above totals $100,411.50. These issues can only be considered in the light of a dues increase.

After a thorough and lengthy consideration of the president's said recommendations, your reference committee recommends that they be approved and that the following resolution be substituted in lieu of Resolution No. 6:

NOW, THEREFORE, BE IT RESOLVED by this House of Delegates that there be a change in the dues structure of the Indiana State Medical Association providing for an increase of $25.00 in the present annual dues, effective January 1, 1965.

AND BE IT FURTHER RESOLVED that the said increase be allocated to the General Fund of the association.

Before moving for adoption of this amended resolution No. 6, it should be mentioned that the reference committee carefully considered the recommendation of the Council and the testimony offered by Drs. Wood, Wilkens, Everly, Neumann and Larson, all supporting as absolutely necessary a $25.00 dues increase, starting in 1965.

Mr. President, I move for the adoption of this amended resolution and the report of the president.

(Motion seconded. Discussed by Dr. Lloyd Hill, Miami county, and Dr. Black).

(The amended resolution and the report of the President were adopted on a roll call vote of 92 to 8).

Mr. President, I move the adoption of this section of the report as a whole, as amended. **(Motion seconded by many, put to vote, and carried.)**

Building Committee Report

Dr. Ralph V. Everly, chairman, presented the following report:

Twenty-nine months ago, your association began the occupation of its own building at 3935 North Meridian Street, marking the completion of the responsibility which you had given to your Building Committee, the Executive Committee and the Council. Those who have had the opportunity to participate in the activities of the association or who have visited the building, I am sure, have been proud of what we can now call our home.

Your committee felt you might be interested in an up-to-date report on the operation cost of your building. The building contains approximately 13,187 sq. ft. The operating expenses for the year, which includes all utilities; janitorial service; yard and parking lot upkeep; janitorial supplies; etc., amounted to $11,427.19 making our operating expense for the building $952.27 per month, or an annual per square foot cost of 87c. Depreciation during the past year has added another $5,870.20, or $489.18 per month. Interest on the bank loan amounted to $3,889.29 for a cost of $324.11 per month. Adding all of these expenses together, we find that our building last year cost us $21,186.68, translating this to a monthly cost, it amounts to $1,765.56. Our total cost per year, per square foot, adding all these together, amounts to $1.60 per square foot per year.

We would remind you that had we leased the same amount of space in a public building, at the rates which were quoted at the time, of $5.00 per square foot for modern, air conditioned space, we would have expended during the past year $65,936.75. Keeping these facts in mind, we can theoretically say that our owning our building has saved us $44,750.07. In addition to this, the increased valuation in the area, due to the construction of new buildings, has more than tripled the valuation of our investment in this property.

The operation of our building has permitted all of our activities, with the exception of the House of Delegates, being carried on in our own headquarters and even this could be done, as we have

had 165 people in our basement at one time.

The feeding of our commissions and committees has been somewhat of a problem in view of the fact we do not have a warming kitchen or facilities for serving hot food or taking care of the dishes. Therefore, our commission members have been on a "ham, beans, and potato salad circuit" for all these months and your committee feels it is time for the association to seriously consider completing the basement by placing a ceiling in it and the installation of a warming kitchen.

Several of our officers have followed the lead of past-president Glock in contributing their expense checks for attending meetings to the fund for building a kitchen.

We recommend to the House of Delegates that they approve these additional improvements to our property.

Your Building Committee also would like to propose that the association give serious thought to the acquisition of additional ground in order to protect our investment during the coming years. It should be pointed out that had the association bought additional frontage on Meridian Street at the time we bought our present location, within less than a year and a half the association could have made over $100,000.00 which would have more than paid the balance on the building, but of course now, it is too late. However, there are two properties immediately to the east of us extending from our back line clear through to Pennsylvania Street and your committee at this time has no idea as to what this property would cost. But your committee would recommend that the association investigate and purchase this additional property, as the time may come when we will need additional space for operation and if we wait until this property is sold for other purposes, we will find ourselves in a position of not being able to expand our facilities. This has apparently been the history of medical associations of other states who have constructed their own headquarters with the feeling the space constructed would last them until the end of time, but this has not proven the rule and they have found it necessary to abandon their existing property and purchase another location and start all over again in order to have what was necessary to take care of their activities.

Your committee does not feel the economics of our times are going to deflate within the immediate, foreseeable future. The tendency of our Federal government has been to encourage inflation and it appears this will go on for several more years. Therefore, while we could have purchased this property for less some two years ago than we could possibly purchase it today, we are sure we can purchase it today for less than we could purchase it the next year or the year after

Your Building Committee desires to express its appreciation to the officers of the association for the help and counsel they have accorded our committee; to the auxiliary for its generous contribution in equipping the basement with tables and chairs; and to the physician members who have been so complimentary in their remarks concerning the facilities offered in our building.

We would hope that those of you who have not as yet visited the building will take the opportunity to do so while attending this convention. While most of the staff are on duty at the convention site, there is a skeleton staff at the building who will be most happy to show you through the building.

RALPH V. EVERLY, M.D. *Chairman*
JACK E. SHIELDS, M.D.
FREDERIC W. BROWN, M.D.
R. CASE HAMMOND, M.D.

REFERENCE COMMITTEE ACTION

Dr. Eugene F. Senseny, chairman, presented the following report:

Building Committee Report

The report of the Building Committee as presented was studied by this committee and testimony was heard from Dr. Everly, chairman of the committee. The report consists of two parts. The first dealt with the addition of a warming kitchen and the completion of the basement. The second part requested approval to investigate the purchase of two lots to the east of our existing property and extending to Pennsylvania Street.

The reference committee recommends that the Building Committee and the Council proceed to investigate this matter and see what can be developed and that the above expenditures for completion of the basement be undertaken as soon as practicable.

Mr. President, I move the adoption of this section of the report.

(Motion seconded by many, put to vote, and carried.)

Supplemental Report of the Committee on Student Loan

Dr. Lester D. Bibler, chairman, presented the following supplemental report:

The action taken by the Council at its July 19 meeting was referred to the Student Loan Committee as follows:

> **"Dr. Steen's motion 'that the Student Loan Committee be instructed to bring to the Council some information regarding their past performance, their future anticipated needs, and so forth, with regard to funds, so that at some future date, not later than the end of this year, we may set a ceiling on what the ultimate total amount of cash should be in the Student Loan Fund' was taken by consent."**

At a meeting of the Student Loan Committee, on motion of Dr. Neumann and Dr. Nurnberger, the committee voted to recommend that in view of the apparent decrease in the number of applications being received at the present time that this year a contribution to the Student Loan Fund be deferred because adequate funds are available to meet requests for loans and it is felt that it is not necessary to increase the reserve fund at this time. Inasmuch as the resolution infers that this should

be done, the committee desires to make a correction to the effect that this shall be done only for the year 1964, in order to alleviate the financial condition of the association. The committee therefore recommends that this action be for the year 1964 only and that the request for additional funds be made on a year-to-year basis according to needs.

This is the recommendation of the Student Loan Committee and further discussion of this will be presented at the reference committee meeting.

REFERENCE COMMITTEE ACTION

Dr. Eugene F. Senseny, chairman, presented the following report:

Student Loan

Your committee next considered the report of the Student Loan Committee as printed in the Handbook and the supplemental report presented to the House at the opening session.

Your committee recommends the approval of the report as printed in the Handbook.

Mr. President, I move the adoption of this section of the report.

Next, we considered the supplemental report and the resolution it contains and the committee recommends the adoption of this report and the resolution.

Mr. President, I move the adoption of this section of the report.

(Motion seconded, put to vote, and carried.)

The committee also recommends that this House commend the Student Loan Committee for their excellent report and for their outstanding work.

Mr. President, I move the adoption of this section of the report.

(Motion seconded, put to vote, and carried.)

Mr. President, I move the adoption of this report as a whole.

(Motion seconded by many, put to vote, and carried.)

Resolution No. 9

Introduced by: MARION COUNTY MEDICAL SOCIETY

Subject: NOMINATION OF DONALD E. WOOD, M.D., OF INDIANAPOLIS, FOR PRESIDENT-ELECT OF THE AMERICAN MEDICAL ASSOCIATION

WHEREAS, Donald E. Wood, M.D., has long been respected as a physician by his peers, and

WHEREAS, Dr. Wood has for many years given unreservedly of himself in service to his colleagues in medical, social, economic and political fields, and

WHEREAS, he is known and admired nationally by doctors and by thousands of laymen as the result of his travels throughout the United States in behalf of the medical profession, and

WHEREAS, he has been accorded many honors in his illustrious career, including the presidency of Marion County Medical Society, the presidency of the Indiana State Medical Association and chairmanship of the Board of Directors of the American Medical Political Action Committee, and

WHEREAS, medicine has urgent need of a leader of his stature, perception, wisdom and vigor and, in turn, his elevation to the highest office in his professional organization would be fitting reward for his dedication, and

WHEREAS, Dr. Wood has the complete endorsement of his fellow county society members,

THEREFORE, BE IT RESOLVED, that the House of Delegates of the Indiana State Medical Association request the Indiana delegates to the American Medical Association to place the name of Donald E. Wood, M.D., in nomination for President-elect at the AMA meeting in Miami Beach, in November, and

BE IT FURTHER RESOLVED, that the Indiana delegates to the American Medical Association be requested to use intensively every means at their command to insure the election of Dr. Wood.

REFERENCE COMMITTEE ACTION

Dr. Eugene F. Senseny, chairman, presented the following report:

The last order of business considered by this reference committee was a resolution by Marion County concerning the support of Dr. Wood as a candidate for president-elect of the American Medical Association at the Miami meeting to be held November 29. You have all received a copy of this resolution. This committee wholeheartedly supports this resolution and urges that the members of this association support this 100%. Mr. President, I move that this report be adopted immediately by unanimous action of this House. I so move.

(Motion duly seconded, put to vote, and carried.)

The committee takes this opportunity to thank the many members who appeared before it to discuss these matters, to the officers of the association who were so generous with their time and in giving us complete information, and I would like to express my personal appreciation to the other members of this committee for their assistance.

Mr. President, I move the adoption of this report of the Reference Committee on Miscellaneous Business as a whole.

(Motion seconded by many, put to vote, and carried.)

INSURANCE

The following matters were referred to the Reference Committee on Insurance. All reports will be found on the pages indicated in the September 1964, Vol. 57, No. 9, *Journal* of the Indiana State Medical Association.

Commission on Medical Economics and Insurance (pages 1042-44)

Report of Glen V. Ryan, M.D., president of Blue Shield (handed to each delegate)

REFERENCE COMMITTEE ACTION

Dr. Clarence G. Kern, chairman, presented the following report:

The following matters were referred to the Reference Committee on Insurance:

Report of President of Blue Shield — Glen V. Ryan, M.D.

The president's report was carefully studied and the committee noted that Blue Shield is still doing an excellent job and the committee commends the president for his fine report.

Mr. President, I move the adoption of this portion of the report.

(Motion seconded, put to vote, and carried.)

Medical Economics and Insurance

This report was read and discussed and the committee takes note of the paragraph at the top of page 180 in the Handbook which reads as follows:

"Mr. James Waggener, Executive Secretary, brought to our attention certain criticism of the AMA Disability Income Plan, particularly the fact that it does not provide benefits until the *full waiting period of a year* has elapsed from the beginning of the sickness or disability from the accident. It was also noted that it has been more or less the policy of the ISMA neither to approve or disapprove any particular insurance program. After reviewing the history of the development of this policy and with the realization that (1) the AMA Disability Plan was designed primarily to supplement existing state programs and therefore, of necessity, would fall short in coverage since we had no plan in existence (2) there can be certain economic advantages to group insurance plans as contrasted to private contracts and (3) it can be good public relations for the ISMA to offer an additional benefit of membership in the form of insurance plans (we have none); this commission has re-evaluated its position on this policy and through a motion made by Dr. Goodman and seconded by Dr. Beeler, recommended to the Council that the Indiana State Medical Association endeavor to develop a group disability program, primarily to cover the first year of disability, later plans to be developed if approved by the Council."

The Committee wishes to suggest that the recommendations of the commission be followed and that the commission should refer to the report of the "Special Committee on Disability Insurance" in 1950 and published in the 1950 November *Journal of the Indiana State Medical Association*, page 1119, setting forth the minimum standards for disability insurance which action was approved by the Council at that time. We approve of this section of the commission's report embodying these suggestions.

Mr. President, I move the adoption of this portion of the report.

(Motion duly seconded, put to vote, and carried.)

The committee also wishes to call your attention to the last paragraph on page 180 of the Handbook which is as follows:

"Upon the suggestion of Dr. W. R. Van Den Bosch this commission recommends to the House of Delegates for direction of the Council, the establishment of a committee to study and devise a plan of action to be taken by the Indiana State Medical Association when and if the association or component societies are faced with a situation similar to that of our colleagues in Belgium, Sweden, Italy, Argentina, etc. where government or an insurance company takes undue measures that infringe upon the rights of free medicine and threaten good medical practice. He suggests that the basic principle in the association's plan should be the realization that no third party's restrictive mandates could exist very long without the doctors' cooperation in their paper work. It was also suggested that the 'plan' anticipate retaliatory measures directed at physicians through economic pressures."

Your committee recommends that the last sentence in this paragraph be deleted because the committee felt that punitive measures should not be anticipated.

Mr. President, I move the adoption of this portion of the report as amended.

(Motion seconded by many, put to vote, and carried.)

Mr. President, the Reference Committee on Insurance wishes to commend the Commission on Medical Economics and Insurance for their diligent work. I move the adoption of their report, as a whole, as amended.

(Motion seconded by many, put to vote, and carried.)

Mr. President, I want to thank the members who attended the meeting for this excellent discussion and I wish to thank the members of the committee, Dr. Caylor, Dr. Thomas, Dr. Boyer and Dr. Dukes, for their excellent help.

Mr. President, I move the adoption of this report as a whole.

(Motion seconded, put to vote, and carried.)

ELECTION OF OFFICERS

The following officers were elected:

President-elect — Kenneth O. Neumann, M.D., Lafayette

Treasurer — Ottis N. Olvey, M.D., Indianapolis

Assistant Treasurer — Lester H. Hoyt, M.D., Indianapolis

AMA delegates and alternates for term expiring December 31, 1966:

Delegates: Harold C. Ochsner, M.D., Indianapolis; E. S. Jones, M.D., Hammond; Francis L. Land, M.D., Fort Wayne.

Alternates: James H. Gosman, M.D., Indianapolis; Robert M. Brown, M.D., Marion; Frank H. Green, M.D., Rushville.

ADDRESS OF PRESIDENT-ELECT

I should like to thank each of you for this honor that you have given me. I appreciate it greatly and we'll do the best job that we know how. I would like to thank the members of my local society who have been most kind in following through and in taking care of my patients when I have been down here for Council meetings. They have done a tremendous job. I appreciate it; I owe them a

great debt, and it has been most rewarding to have this type of cooperation from my colleagues. To try to follow or to attempt to continue the leadership that this organization has had for the last few years with Dr. Owsley, Dr. Glock, Dr. Wood and the efforts that Dr. Black has put out and will be putting out is a most difficult challenge. It is also a great opportunity. We have a most difficult time ahead of us. Our profession, our association and even our personal freedoms are threatened. I earnestly request the help of each of you in attempting to do a job to improve our situation in all phases.

Places of Future Annual Conventions

Dr. Eugene F. Senseny, on behalf of the Allen County Medical Society, extended an invitation to the association to meet in Fort Wayne in 1968, and **on motion of Dr. Richard Wagner, Huntington, seconded by many, the invitation was accepted.**

Following discussion, **on motion of Dr. Peter Petrich, Attica, duly seconded, selection of place for the 1969 annual convention was deferred.**

The chairman announced that:

the 1965 convention will be held in Indianapolis, October 12, 13 and 14;

the 1966 convention will be held in French Lick, October 10, 11 and 12;

the 1967 convention will be held in Indianapolis, October 10, 11 and 12;

the 1968 convention will be held in Fort Wayne.

Resolutions of Appreciation

Appreciation of Speakers

Dr. John M. Paris presented the following resolution which was adopted unanimously:

WHEREAS, this is a campaign year and candidates for national office are overtaxed with appearances;

AND WHEREAS, these individuals are called upon constantly by many organizations to make appearances;

AND WHEREAS, the appearance of Senator R. Vance Hartke, State Senator D. Russell Bontrager and Congressman Charles Halleck at the 115th annual convention, and Senator Everett Dirksen's telephone communication to us today, added immeasurably to the success of the convention;

NOW THEREFORE BE IT RESOLVED, that the Indiana State Medical Association commend and thank the aforementioned gentlemen for their participation in the 115th annual convention of this association.

Appreciation of Entertainment Committee

Dr. William R. Tindall presented the following resolution which was adopted by consent:

WHEREAS, the entertainment portion of any ISMA annual convention requires untold hours of hard work and preparation;

AND WHEREAS, the entertainment provided at the 115th annual convention of the Indiana State Medical Association can be considered one of the most successful entertainment programs ever staged for a convention;

AND WHEREAS, without the many hours of work put in by Dr. and Mrs. William M. Kendrick and Dr. Ray H. Burnikel and the many other doctors and their wives who assisted them, there would not have been such a successful entertainment program;

NOW THEREFORE BE IT RESOLVED, that the sincere thanks and appreciation of every member of the Indiana State Medical Association be expressed to the Kendricks, Dr. Burnikel and the other doctors and their wives by the passage of this resolution.

Appreciation of Staff

Dr. Frank H. Green presented the following resolution which was adopted by consent:

WHEREAS, the success of any convention depends upon innumerable hours of hard work and preparation;

AND WHEREAS, no convention could be planned, organized and brought to fruition without the work of the ISMA staff;

AND WHEREAS, the staff is called upon at all hours of each day of the convention to answer outside requests for aid and assistance besides carrying on with their assigned tasks;

AND WHEREAS, the 1964 ISMA Convention was one of the most successful conventions ever held in the history of the association;

NOW THEREFORE BE IT RESOLVED, that the entire Indiana State Medical Association sincerely and gratefully thank each and every staff member who in any way helped with the success of the 115th annual convention.

Appreciation of President

Dr. E. S. Jones presented the following resolution which was adopted unanimously:

WHEREAS, this past year the Indiana State Medical Association has been fortunate in having as its president Dr. Donald E. Wood, and

WHEREAS, he has given unstintingly of his time to the affairs of organized medicine, both on a state and national level, with vigor and enthusiasm; and

WHEREAS, as official spokesman of the association on many occasions throughout Indiana, he has expressed organized medicine's viewpoint on very important things; and

WHEREAS, such activity by the Indiana State Medical Association's president is becoming each year more demanding; and

WHEREAS, he has met his obligation as president with dedication and sincere purpose;

NOW THEREFORE BE IT RESOLVED, that this House of Delegates recognize the work of Dr. Donald E. Wood in behalf of his fellow physicians and extend to him their heartfelt thanks and appreciation.

Adjournment

The House of Delegates adjourned, *sine die*, at 4:00 p.m., Thursday, October 15, 1964.

Association News

EXECUTIVE COMMITTEE

September 23, 1964

Present: Ralph V. Everly, M.D., chairman; G. O. Larson, M.D.; Don E. Wood, M.D.; Joe M. Black, M.D.; Kenneth O. Neumann, M.D.; Irvin W. Wilkens, M.D.; Ottis N. Olvey, M.D.

Frank B. Ramsey, M.D., editor of *The Journal;* Robert Hollowell and Ralph Hamill, attorneys and James A. Waggener, executive secretary.

Guests: Francis L. Land, M.D., Guy A. Owsley, M.D. and Jack E. Shields, M.D., delegates to the AMA.

James M. Gosman, M.D., Robert M. Brown, M.D., Frank H. Green, M.D., William B. Challman, M.D., John M. Paris, M.D., alternate AMA delegates.

Membership Report:

Number of members as of August 31, 1963		4,340
1964 members as of August 31, 1964:		
Full dues paying	3,779	
Residents and interns	129	
Council remitted	48	
Senior	326	
Honorary	3	
Military	50	
Total 1964 members as of August 31, 1964		4,335
Number of members as of August 31, 1963		4,340
Loss over last year		5
Number of AMA members as of August 31, 1964		4,231
Total 1963 AMA members as of August 31, 1963		4,237
Loss over last year		6
1964 AMA members: Dues paying	3,675	
Exempt, but active	556	
	4,231	
Number who have paid state dues but not AMA dues as of August 31, 1964		103

Headquarters Office

The question of the appointment of a committee to study the use of the building facilities by specialty groups was referred to the chairman and the executive secretary and a committee of their choice to bring back a report, on motion of Drs. Wilkens and Black.

The secretary reported on the survey being made by the Internal Revenue Service and the fact that the attorney had had several tax questions which he had referred to Troy Thurston, former member of the Advisory Board to the United States Internal Revenue Service and had been paying for these reports out of his own pocket. The secretary recommended that in cases such as this, the legal counsel be reimbursed his cost in obtaining these opinions. This recommendation was approved on motion of Drs. Larson and Neumann.

The secretary reported on his conversation with the American Medical Association concerning the advertising program.

The secretary reported that the United States Chamber of Commerce had informed the Indiana State Chamber of Commerce that their annual dinners in the future would be held on Tuesday nights which is normally the night used by the state chamber for its dinners in Washington. The question was whether or not the Indiana delegation should continue to hold its meeting with the Indiana congressional delegation on a Monday night of the week of the United States Chamber of Commerce meeting. On motion of Drs. Wood and Larson, it was voted that the association should continue to hold its annual dinner on Monday night.

Building Matters

The request of the Indianapolis Medical Society to use the headquarters building for a meeting of their society on Tuesday, October 6, 1964, was approved by consent. The local society is to be a guest of the association at this time, but in the future, they will be expected to pay for the cost of opening the building for any meetings they may hold there.

Treasurer's Office

Report of the treasurer was approved on motion of Drs. Wilkens and Larson.

Annual Convention

The committee reviewed the final program as outlined.

In discussing the guest list for the president's luncheon, upon motion of Drs. Larson and Olvey, the president was authorized to expend up to $1,000.00 of association funds for guests at this luncheon.

The plans for the entertainment program and the president's reception were reviewed by the president.

Legislation

National: The president reviewed the status of HR 11865 and the secretary read a letter from Merck & Co., Inc., concerning the action taken by their president on the Johnson Committee.

Organization Matters

The secretary reported on the Lawrence county matter. He had written to Lawrence county on July 23 and had not received a reply.

Actions taken by the Board of Trustees of the AMA at its meeting following the San Francisco session were reviewed for the information of the committee.

A letter requesting participation in the program to require mandatory legislation on PKU screening from the Indiana Association of Retarded Children was read for the information of the committee.

A letter from the American Crash Injury Research organization, complimenting the association for its participation was read and it was taken by consent that *The Journal* editor be requested to publish this in *The Journal.*

A letter from the Federation of State Medical Boards concerning the distribution of their bulletins was read.

A letter from the State Medical Society of Wis-

consin containing a report on their legal action on podiatrists and Blue Shield was read for the information of the committee.

The request of the Indiana Congress of Parents and Teachers for the association to participate and to supply information on materials and a program designed to conduct sex education programs among adults was read and upon motion of Drs. Neumann and Black, the association will supply two booklets on this subject to the PTA.

The chairman of the Council discussed a letter which he had received from the Indiana Association of Pathologists, stating that this also would be discussed by the Council at its next meeting.

A letter from Dr. Edwin Dyar concerning a request for the state association to establish a fee schedule to be used by the Welfare Department in the blind assistance program was discussed. Upon motion of Drs. Larson and Wilkens, it was to be recommended to Dr. Dyar that the Welfare Department arrange these schedules on a county by county basis.

A letter from Dr. E. T. Edwards was reviewed for the information of the committee.

A proposed letter directed to the Department of Education, State of Indiana objecting to lowering the standards for those involved in health education and coaching was approved on motion of Drs. Black and Larson.

A letter from the Commissions on Public Information and Governmental Medical Services concerning the medical self-help television program was reviewed for the information of the committee.

The agreement between the Indiana National Bank and the state medical association covering the student loan program was reviewed. The secretary pointed out that no one had ever been authorized to sign this agreement and on motion of Drs. Larson and Neumann, the treasurer was authorized to sign on behalf of the association.

Judge Hamill informed the committee of the proposal to build two additional office buildings immediately north of Fortieth Street on the east side of Meridian Street and requested the association to direct a letter to the Zoning Variance Committee that the association would not oppose the granting of such a variance.

New Business

A letter from the Pennsylvania Medical Society announcing that they will place the name of Dr. James Z. Appel in nomination for president-elect of the American Medical Association was read.

The Journal

The request of the Professional Purchasing Association to publish an ad in *The Journal* was discussed and the insertion was approved providing the Oklahoma State Medical Association gives this organization its approval.

Future Meetings

Educational Institute—Joint Council on Health Care of the Aging, Cincinnati, September 30-October 2, 1964. No representative is to be sent to this meeting.

Fourth National Congress on Voluntary Prepayment, Las Vegas, October 2-3, 1964. It was decided that the association would not send anyone to this conference.

National Stroke Congress, Chicago, October 29-31, 1964. By consent it was decided that no one would represent the association at this meeting.

First National Conference on Health Education Goals, Chicago, October 30-31, 1964. The chairman of the Commission on Medical Education and Licensure, or someone designated by him, is to represent the association at this meeting.

Fifteenth National Conference on Disaster Medical Care, Chicago, November 7-8, 1964, will be discussed at the next meeting of the committee.

National Conference on Medical Aspects of Driver Safety, Chicago, November 16-18, 1964. By consent no representative is to be sent to this meeting.

Second National Conference on Cardiovascular Diseases, Washington, D. C., November 22-24, 1964. By consent no one is to be sent to this meeting.

First National Conference on Areawide Health Facilities Planning, to be held during the AMA meeting. The staff and any physicians possible will attend this meeting.

Sixth National Conference on Medical Aspects of Sports, Miami Beach, November 29, 1964. Dr. Black will represent the association at this meeting.

AMA Conference on Blood Banking, Chicago, December 11-12, 1964. No representative will be sent to this meeting.

United States Chamber of Commerce Public Affairs Conference, Washington, D. C., February 3-4, 1965, is to be placed on the agenda for the next meeting of the committee.

AMA Clinical Session, Miami Beach, November 29-December 2, 1964. By consent it was agreed that Mr. Bush would attend this meeting.

The committee then met with the AMA delegates and a letter was prepared to be distributed to all AMA delegates, announcing the candidacy of Dr. Wood.

It was further agreed that if the election is to be held at the AMA meeting on Monday morning that the association would hold a reception in Dr. Wood's honor on Sunday evening, November 29. In the meantime it was agreed that all delegates would begin an active campaign toward the election of Dr. Wood and, furthermore, it would be advisable for the delegates to arrive in Florida on Saturday, November 28.

There being no further business the committee adjourned to meet again on Monday, October 12, 1964, at the Columbia Club, Indianapolis.

EXECUTIVE COMMITTEE

October 12, 1964

Present: Ralph V. Everly, M.D., chairman; G. O. Larson, M.D.; Don E. Wood, M.D.; Joe M. Black, M.D.; Kenneth O. Neumann, M.D.; Irvin W. Wilkens, M.D.; Ottis N. Olvey, M.D.

Frank B. Ramsey, M.D., editor of *The Journal;* Ralph Hamill, attorney, and James A. Waggener, executive secretary.

Guests: Harold C. Ochsner, M.D., E. S. Jones, M.D., Francis L. Land, M.D., and Jack E. Shields, M.D., delegates to the AMA.

Robert M. Brown, M.D., alternate AMA delegate.

John F. Spoden, Wil-Ten-Co., Inc.

Membership Report

Number of members as of September 30, 1963	4,342
1964 members as of September 30, 1964:	
Full dues paying	3,787
Residents and interns	129
Council remitted	47
Senior	326
Honorary	3
Military	50
Total 1964 members as of September 30, 1964	4,342
Number of members as of September 30, 1963	4,342
Number of AMA members as of September 30, 1964	4,237
Total 1963 AMA members as of September 30, 1963	4,238
Loss over last year	1
1964 AMA members: Dues paying	3,683
Exempt, but active	554
	4,237
Number who have paid state dues but not AMA dues as of September 30, 1964	105

Headquarters Office

The secretary reported on the statewide advertising program. He also distributed a copy of his remarks made at the Baltimore Journal Conference on tax liability for medical journals.

The president's address, to be given before the House of Delegates, was approved by consent.

Building Matters

The chairman of the Building Committee gave a review of the report he proposed to make to the Council and to the House of Delegates.

The committee discussed with Mr. Spoden of Wil-Ten-Co., Inc., his proposal to exchange weekday parking space in the association's lot for exit onto Fortieth Street and the use of his parking facilities on weekends. After discussion of this, upon motion of Drs. Larson and Olvey the Building Committee was authorized to enter into an agreement with Mr. Spoden to accomplish this purpose.

Treasurer's Office

The treasurer's report upon the balances as of September 30, 1964, was approved on motion of Drs. Larson and Olvey.

The committee then discussed the recommendation which is to be made to the Council for presentation to the House of Delegates for a dues increase and upon motion of Drs. Larson and Neumann, the committee agreed to recommend to the Council a dues increase for 1965 of $25.00.

Annual Convention

The committee briefly reviewed the final program outline and plans for the entertainment, the president's reception and the complaint filed by the Miami County Medical Society concerning the program.

Organization Matters

A letter addressed to Merck employees by the president of Merck & Co., Inc., and letters from the Arizona Medical Association, the Medical Society of New Jersey, the Missouri State Medical Association, Dr. A. C. Offutt and Dr. Robert A. Hedgcock were read for the information of the committee. No action was taken.

Letter from the National Society for Medical Research requesting financial support of the association was reviewed. Upon motion of Drs. Black and Neumann, this request was not approved.

Letter from the National Foundation requesting use of the association's mailing list for sending out announcements concerning the new clinic on birth defects at the Indiana University Medical Center was reviewed and the request was approved on motion of Dr. Neumann, taken by consent.

The secretary read a letter from the Post Office Department questioning the right of the association to have the benefit of the reduced mailing rate on the basis of the association's tax exemption.

Future Meetings

The committee again considered the representative for the fifteenth national conference on Disaster Medical Care to be held in Chicago on November 7 and 8, and upon motion of Drs. Black and Larson, Dr. Charles Alvey or a representative from the Commission on Governmental Medical Services is to represent the association at this meeting.

Public Affairs Conference, Washington, D. C., February 3-4, 1965. On motion of Drs. Neumann and Black, no representative will be sent to this meeting.

AMA Eleventh Annual Conference on Mental Health, March 5-6, 1965. By consent it was agreed to send the chairman of the Mental Health Committee to this meeting.

The committee then met with the delegates to the AMA and discussed the matter of conducting the campaign for Dr. Don Wood for president-elect of the AMA.

Upon motion of Drs. Land and Neumann, it was agreed that Dr. E. S. Jones would serve as chairman of the campaign committee.

Upon motion of Drs. Larson and Wilkens the secretary was instructed to procure telephone credit cards for the AMA delegates and alternate delegates.

There being no further business the meeting was adjourned to meet again at the conclusion of the Council meeting following the final meeting of the House of Delegates on October 15, 1964.

EXECUTIVE COMMITTEE

October 15, 1964

The Executive Committee met in the Candidates Room of the Murat Temple on Thursday afternoon, October 15, 1964, at the conclusion of the Council meeting, with the following members present:

G. O. Larson, M.D.; Joe M. Black, M.D.; Kenneth O. Neumann, M.D.; E. S. Rifner, M.D.; Ottis N. Olvey, M.D., and James A. Waggener, executive secretary.

By secret ballot Dr. Ralph V. Everly was elected chairman of the Executive Committee for the ensuing year.

Dr. Lester H. Hoyt, the newly elected assistant treasurer, was absent.

Dr. Ralph V. Everly, chairman of the Executive Committee, was absent.

There being no further business, the meeting was adjourned, to meet again upon the call of the chairman.

THE COUNCIL

Indianapolis
October 12, 1964

The Council convened at 3:00 p.m., Eastern Standard Time, in Parlors B and C of the Columbia Club, Indianapolis, on October 12, 1964, with Dr. Kenneth O. Neumann, the chairman, presiding. Roll call showed the following present:

Councilors:

First District—P. J. V. Corcoran, Evansville
Second District—E. T. Edwards, Vincennes
Third District—John M. Paris, New Albany (also AMA alternate delegate)
Donald M. Kerr, Bedford, councilor-elect
Fourth District—Robert M. Reid, Columbus
Jack E. Shields, Brownstown, alternate (also AMA delegate)
Fifth District—V. Earle Wiseman, Greencastle
Sixth District—William R. Tindall, Shelbyville
Seventh District—Albert M. Donato, Indianapolis
Charles A. Jones, Franklin, alternate
Eighth District—Donald R. Taylor, Muncie
Ninth District—Kenneth O. Neumann, Lafayette
Albert E. Stouder, Kempton, alternate
Peter R. Petrich, Attica, councilor-elect
Tenth District—Lowell H. Steen, Whiting
Eleventh District—E. S. Rifner, Van Buren
Lowell Hillis, Logansport, alternate
Twelfth District—Milton F. Popp, Fort Wayne
William Clark, Fort Wayne, alternate
Thirteenth District—Jene R. Bennett, South Bend
Raymond E. Nelson, South Bend, alternate

Officers:

Don E. Wood, Indianapolis, president
Joe M. Black, Seymour, president-elect
Irvin W. Wilkens, Indianapolis, treasurer
Ottis N. Olvey, Indianapolis, assistant treasurer

Journal:

Frank B. Ramsey, Indianapolis, editor

Executive Committee:

Ralph V. Everly, Indianapolis, chairman
G. O. Larson, LaPorte.

Guests:

Harold C. Ochsner, Indianapolis, AMA delegate
E. S. Jones, Hammond, AMA delegate
Francis L. Land, Fort Wayne, AMA delegate
Robert M. Brown, Marion, AMA alternate delegate
William B. Challman, Mount Vernon, AMA alternate delegate
A. C. Offutt, Indianapolis, State Health Commissioner
Lester D. Bibler, Indianapolis, AMA Trustee, and chairman, Committee on Student Loan
Lester H. Hoyt, Indianapolis, Professional Advisory Committee, Blue Cross

Staff:

Ralph Hamill, attorney
Howard Grindstaff, field secretary
J. A. Waggener, executive secretary

By consent the Council sent greetings to Dr. Guy Owsley, AMA delegate, who was unable to attend the meeting because of illness.

On motion of Drs. Popp and Steen, minutes of the meeting held on July 19, 1964, were accepted as printed in the September, 1964 *Journal*.

Reports of Councilors

DR. STEEN, Tenth District, announced that the Tenth District Society would meet at Phil Smidt's on October 21, with Congressman Ray Madden, and Arthur Endres of Highland, Indiana, his opponent in the coming election, as the speakers.

DR. BENNETT, Thirteenth District, reported that Dr. Guy B. Ingwell, Knox, had been elected president of the Thirteenth District at the annual district meeting, and Dr. Robert L. Rouen, Elkhart, was elected alternate councilor to replace Dr. Raymond Nelson.

Unfinished Business

1. *Transfer of payment of fees for radiology and pathology services from Blue Cross to Blue Shield.*

a. Letter received from the Indiana Roentgen Society president stating that that society "has passed and repeatedly reaffirmed resolutions in favor of and requesting transfer of payment for professional services from Blue Cross to Blue Shield," and also stating that the request for financial assistance would be submitted to the I. R. S. executive committee.

b. Letter received from the Indiana Association of Pathologists offering financial aid to effect the transfer through "voluntary contributions from pathologists" was read.

c. Dr. Edwards read the following report of the Ad Hoc Committee for Blue Cross-Blue Shield Transfer:

The Ad Hoc Committee reported to the Council at the April 26 and July 19 meetings in 1964.* Information regarding the Indiana Medical Practice Law was presented to the Council which led to the Council's engaging Judge Hamill to investigate certain aspects of the law as they relate to hospitals contracting with Blue Cross to furnish professional services (x-ray and pathology) as hospital services. Judge Hamill's report on this matter is to be presented to the Council at its meeting on Monday, October 12, 1964.

The Ad Hoc Committee's recommendations for future action regarding Blue Cross-Blue Shield transfer of payment for professional services in hospitals will be held in abeyance until after Judge Hamill's report to the Council.

Ad Hoc Committee
for Blue-Cross-Blue Shield Transfer
Lowell I. Thomas, M.D., Indianapolis
Chairman

* See *The Journal*, September, 1964, pp. 1018 and 1019

C. P. VanMeter, M.D., Indianapolis
E. T. Edwards, M.D., Vincennes
Don Taylor, M.D., Muncie
Jene Bennett, M.D., South Bend

d. Judge Hamill reported that the brief is ready to be presented and he and Mr. Hollowell were awaiting instructions of the Council as to how to proceed.

Further discussion of this matter was deferred until additional clarification is received from the pathologists.

Reports of Officers

DR. DONALD E. WOOD, president, read the talk which was to be delivered before the first meeting of the House of Delegates at 7:00 p.m., October 12. (See pages 1426-28, December *Journal*).

DR. JOE M. BLACK, president-elect: At this time I want to thank you all for the opportunity of having the chance to become president of this great state association. My appeal tonight will be basically one of let's all get our shoulder to the wheel. I am going to endorse most of the things Don has talked to you about. I am going to ask you to take an interest in your society, to increase the general public's interest in our society and to do a job. I feel that today organized medicine is one of the last bastions against the Social Security approach to medical care. And this is my speech for tonight.

DR. IRVIN W. WILKENS, treasurer, discussed the financial status of the association, reporting that the cash balance as of September 30, 1964, was $32,111.75. "In addition, $20,000.00 is on deposit which will be available December 31, 1964, to pay our obligation to the AMERF.

"While we have a cash-in-hand balance of $32,111.75, our anticipated obligations between now and January 1 amount to $98,572.77. These obligations include the cost of this convention, $18,940.00 to the Student Loan Fund and the same amount to AMERF. We expect to have to pay *The Journal* $7,807.00 to finish out its year and approximately $30,000.00 for operation of the headquarters office, committees, commissions, etc., all of which go to make up the estimated total of $98,572.77 which we will have to pay by January 1.

"Subtracting the $52,111.75 which we now have in cash leaves us an anticipated cash deficit of $46,461.02.

"It is evident that on this basis I will find it necessary to borrow some money to see our association through until the receipt of the 1965 dues.

"If the House of Delegates concurs with the recommendation of the Student Loan Committee and permits us to use the $18,940.00 earmarked for the Student Loan Fund to help to defray this deficit, it will be of great assistance. Also, if they will permit us to borrow $10,000.00 from the old Student Loan Fund, these two actions would materially reduce the amount of money which I may have to borrow to see us through until January 1.

"We have been operating on a deficit budget for several years and if we continue to operate as we have been we will soon consume all reserves which we have and I concur most heartily with the recommendation of the Executive Committee and the Council that it is absolutely necessary for the association to increase its dues if it is to continue to function."

DR. FRANK B. RAMSEY, editor of *The Journal*: The last *Journal* financial statement was for the last of August. At that time, since the start of the fiscal year, we were about $2,200.00 ahead. We had received our budgeted advertising revenue at almost the same percentage that we'd spent on our budgeted printing bill, which is a pretty good indication that we are approximately even with the budget and also with the finances.

I'd like to report to you on the possibility that the Internal Revenue Service may decide that they should impose an income tax upon the advertising income and exhibit income of all associations who are otherwise considered non-taxable. I had a letter yesterday from our advertising agent in New York who has just talked to the business manager of the *New England Journal of Medicine*, to report that the Massachusetts State Medical Society which publishes the *New England Journal* has received a bill from the Internal Revenue Service for taxes on their advertising income for 1958 to 1963; the total bill comes to just under a half-million dollars.

This may not mean that associations who actually lose a little money on their publications will ever be taxed, since the *New England Journal* is one of the prime examples of a money-making publication. That is probably the reason they were billed first by the Internal Revenue Service. This will go through a court of law, and if the revenue service wins, then they'll be able to narrow their indications for tax paying and may eventually include us. This fortunately for us puts us in a bracket with some very large and powerful and popular associations. The National Geographic Society is one of these; all publications of labor unions will be included. All AMA publications are included.

In my job as president of the Advertising Bureau, I have been interested in it all summer and have talked to the legal department of the AMA. They have informed me that there have been two bills introduced into the Congress that just adjourned to specifically exempt from taxation the advertising and exhibiting income of non-taxable associations. These will no doubt be introduced when the next Congress meets and there is great hope that these bills will pass. I believe there is some basis for that hope, since it does include not only the medical organizations but the labor organizations and such educational associations as the National Geographic.

REPORT OF AMA DELEGATES: DR. E. S. JONES spoke on the arrangements being made for nominating and electing Dr. Don Wood president-elect of the AMA at the Miami meeting in December.

DR. LESTER D. BIBLER, member of the AMA Board of Trustees, discussed some of the pertinent items which came to the attention of the AMA Board of Trustees at its last meeting.

(1) Suggestion that a special section of space medicine be created. Action was deferred as it was thought that space medicine might be able to operate under the Section on Military Medicine.

(2) Suggestion that the accreditation of nursing homes be operated under the Joint Commission on Accreditation of Hospitals. This is to be discussed by the Liaison Committee with the Nursing Association, the American Hospital Association and the AMA.

(3) Formation of an Ad Hoc Committee relative to education for general practice, the committee to be composed of members of the Council on Medical Education, the American Academy of General Practice and the Association of Medical Colleges. "This is the fourth committee of the AMA which has been created in recent years for the purpose of stimulating new doctors to do general practice, or family practice. This is a critical situation. We are trying to answer this problem, but up to the present time we have made very little progress. Incidentally, Frank Land is vice-chairman of this new committee."

(4) World Medical Association — selection of a new secretary-general.

(5) Election of a president-elect of the AMA at the Miami meeting to take Dr. Ward's place, and election in June of a president-elect for the ensuing year.

(6) AMA forum, to be held in Chicago on November 1, with representatives from the sections on Section Work, Medical Service, Medical Education and Legislation.

(7) Meeting of the Congress on Medicine and Pharmacy, which will be held next year.

(8) Elections: Joint Commission on Accreditation of Hospitals, Dr. H. C. Hesseltine and Dr. Hugh Carmichael, re-elected; Dr. Dwight Wilbur, an AMA trustee, elected a new member on Accreditation Commission. Dr. Jack Jones renominated for Commission on Medical Practice. Dr. Ray Rice nominated on Commission on Research.

(9) Openings for personnel in sections on dermatology and allergy.

Matters Referred to Council by Executive Committee

1. *Better Business Bureau membership for* 1965. **On motion of Drs. Wiseman and Popp, the Council authorized the payment of a $175.00 membership in the Better Business Bureau for 1965.**

2. **Recommendation of the Executive Committee that the state membership dues be increased $25.00 per member, effective January 1, 1965, was accepted on motion of Drs. Edwards and Rifner.**

Economic and Organization Matters

1. *Remission of state dues.* **On motion of Drs. Donato and Corcoran, remission of the state dues of a member of the Hendricks County Medical Society was approved as the member in question is in missionary service in India.**

On motion of Drs. Steen and Paris, the Council voted remission of the state dues for one year of a member of the Lake County Medical Society because of illness and financial hardship.

2. *Nomination of Blue Shield Board member-at-large to replace W. Harry Howard, M.D., Hammond, whose term will expire March,* 1965. **On motion of Drs. Paris and Edwards, the Council nominated Dr. Earl W. Mericle, Indianapolis.**

In view of Dr. Howard's long term of service with Blue Shield, as well as with Indiana Medicine, **it was taken by consent that the Council would recommend to the Blue Shield Board that Dr. Howard be carried as an honorary member of the Blue Shield Board.**

3. *District nominations for Blue Shield Board of Directors members for three-year terms ending March,* 1968, *were confirmed as follows*:

G. W. Willison, Evansville, Internal Medicine, District 1

H. T. Goodman, Terre Haute, General Practice, District 5

F. W. McDowell, Muncie, General Surgeon, District 8

R. W. Vermilya, Lafayette, Anesthesiology, District 9

Mahlon F. Miller, Fort Wayne, Obstetrics and Gynecology, District 12

On motion of Drs. Edwards and Steen, these nominations were approved and the secretary was instructed to so notify the Blue Shield Board.

4. *Election of Journal editors.* **On motion of Drs. Steen, Edwards and Popp, the present editor, Dr. Frank B. Ramsey, Indianapolis, and Drs. A. W. Cavins, Terre Haute, Lall G. Montgomery, Muncie, David A. Bickel, South Bend, and Samuel R. Mercer, Fort Wayne, present associate editors, were re-elected for 1965.**

New Business

1. *Amendments to Constitution to be voted on by House of Delegates.* All amendments to the Constitution to be voted on by the House of Delegates (published in the September, 1964, *Journal* and in the delegates' handbook) were approved by the Council with the exception of amendment No. 6 which reads as follows:

"BE IT RESOLVED: that Article VI of the Constitution of the Indiana State Medical Association be amended by deleting therefrom the words 'and at all times shall be the finance committee of the Association.' "

Dr. Paris moved that the Council oppose the passage of amendment No. 6 as this would take away from the Council "the authority of having something to do with the finances of this association." Motion seconded by Dr. Corcoran and discussed by many, following which Dr. Steen moved that the above motion be amended to include "that the legal counsel be instructed to insert in the Constitution and Bylaws in whatever manner is necessary that the Council shall approve the budget of the association." Dr. Steen's amendment to the motion made by Dr. Paris was duly seconded, put to vote, and carried. The motion as amended was put to vote and adopted.

The chairman of the Council asked Dr. Paris to present the Council's opposition to amendment No

6 to the House of Delegates.

2. *Resolutions to be introduced* in the House of Delegates were read by title and discussed.

Matters from Committees and Commissions

1. *Student Loan Committee.* Dr. Bibler, chairman, presented the following supplementary report **which was accepted and approved for presentation to the House of Delegates on motion duly made, seconded, put to vote, and carried:**

The following action, taken by the Council on July 19, 1964, was referred to the Student Loan Committee:

"Dr. Steen's motion 'that the Student Loan Committee be instructed to bring to the Council some information regarding their past performance, their future anticipated needs, and so forth with regard to funds so that at some future date, not later than the end of this year we may set a ceiling on what the ultimate total amount of cash should be in the Student Loan Fund' was taken by consent."

The Student Loan Committee met on September 23, 1964, and voted to recommend that in view of the apparent decrease in the number of applications being received at the present time, this year's contribution to the Student Loan Fund be deferred because adequate funds are available to meet requests for loans and it is felt that it is not necessary to increase the reserve fund at this time. Inasmuch as the Council action infers that this should be done, the committee desires to make a correction to the effect that this shall be done only for the year 1964 in order to alleviate the financial condition of the association. The committee therefore recommends that this action be for the year 1964 only and that the request for additional funds be made on a year-to-year basis, according to need. This was accepted by the Student Loan Committee.

For further information of the Council Dr. Bibler stated he had discussed this matter with Mr. Peake at the University and Mr. Peake feels that there may be some change in the demand for loans in the near future. "So, I would suggest that we not encumber this Student Loan Committee with any positive action other than from year to year due to the possibility of more participation by the students in the near future. At the present time we have an adequate fund to care for the Student Loan program and we do not care to put additional money in it, because once it gets to the bank, it is committed to this loan fund. As long as we keep it in our own General Fund, you have access to these monies. For that reason, we offer this supplementary recommendation."

2. *Council Liaison Committee with Blue Shield.* Dr. Steen, chairman, reported on Blue Shield matters of interest to the Council.

3. *1964 Convention.* The secretary commented briefly on the arrangements for entertainment and on exhibit sales.

4. *Recommendations of the Commission on Constitution and Bylaws* on proposed changes in the Bylaws were discussed by Drs. Corcoran, Challman and Popp. These amendments will be presented to the House of Delegates in the regular order of business.

Reports of Guests

1. DR. A. C. OFFUTT, State Health Commissioner, discussed the work of the Maternal Mortality Study Committee in reviewing the program of grants for maternity and infant care projects under P. L. 88-156 and the recommendations made by the committee.

Dr. Offutt reported that "It was the recommendation of the committee that the Indiana State Medical Association support efforts which will promote adequate maternal and infant care programs throughout Indiana and that support of such projects under the maternal and infant care program as provided by P. L. 88-156 be utilized where such support is indicated in meeting the goal of adequate maternal and infant care. . . .

"In essence, P. L. 88-156 provides for federal grants for infant and maternal care. One of the major items is that there has to be some condition which would make it mandatory to have this kind of thing. . . . This, of course, would be limited largely to low income brackets in cities, in rural areas, and in economically depressed areas where the needs of these patients and their infants are not being met. Item 3 of the Act says that grants may be made to the state health agency with the consent of the state health agency. This means that we would have to agree to accept the grants before they will be made to us. In the case of a project in which such an agency is unable or unwilling to participate, then it may be made to the health agency of any political subdivision in the state.

"This would make available a broad spectrum of diagnostic and specialist consultation services. It would provide for hospitalization during the prenatal period as well as during labor and delivery. It would also provide for medical and intensive nursing care for the premature and for high-risk infants, public health nursing, nurse midwifery, and medical, social and nutritional services. It also will include dental care and will respond to the special needs of the population by providing for other things such as homemaker services, blood, drugs and transportation.

"We would be pleased to have you accept the committee's recommendation which would then let us have it from here on. . . . I think the committee recommends that we accept this so that we will have some way of saying that yes we are interested, *but* we want to know who is going to do what, and who gets paid and why must this be done in the area that it's being done."

On motion of Dr. Bennett, seconded by several, action on this matter was deferred until the January meeting of the Council.

DR. OFFUTT also discussed the movement in Congress to provide $5,000,000.00 to study rehabilitation and medical care of selective service rejects, and asked the Council to express an opinion on this matter.

"Now, I bring this to your attention for three

reasons: It will involve public health; it will involve medical care administration and rehabilitation — then this is a bigger program than it might appear in the somewhat small beginning — and it will involve designation of some state agency to develop the program."

On motion of Drs. Edwards and Popp, the Council voted to refer this problem to the Commission on Public Health for study, with a recommendation that the Indiana State Board of Health be considered as the administrative agent in Indiana for the program of rehabilitation of and medical care of selective service rejectees. The Commission on Public Health is to be asked to report back to the Council at its January meeting.

2. DR. LESTER HOYT, member of the Blue Cross Professional Advisory Committee, commented mainly to counteract some of the rumors that have been going around and as published in the *Wall Street Journal* that Blue Cross was about to go broke, that Blue Cross is the strongest now that it has ever been.

The chairman announced that an officially called meeting of the Council will be held each morning during the convention at 7:30 a.m.

There being no further business the Council adjourned, to meet again on Thursday, October 15, 1964, in the Candidates Room, Murat Temple, immediately following adjournment of the House of Delegates.

THE COUNCIL

Indianapolis
October 15, 1964

The Council met for its second meeting at the close of the final session of the House of Delegates on Thursday, October 15, 1964, in the Candidates Room at the Murat Temple, Indianapolis, with all councilors, five alternate councilors, the president, the treasurer, the assistant treasurer, the editor of *The Journal* and a member of the Executive Committtee, present.

Elections for 1964-65

1. *Chairman of Council.* By secret ballot, Dr. Eugene S. Rifner, Van Buren, was elected chairman of the Council for 1964-65.

2. *Executive Committee.* Upon motion of Dr. Edwards, seconded by several, Drs. Ralph V. Everly and G. O. Larson were re-elected members of the Executive Committee for 1964-65.

There being no further business, the meeting was adjourned.

X65-2547

Indiana state medical association.
Journal
v.57, 1964.

DATE	ISSUED TO
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